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ABSTRACT

Participants in this pediatric round table met to (1) detrivialize child care; (2) advance the concept of child care as a continuum of services; (3) establish the role of health care professionals in the design and implementation of high quality child care; and (4) develop action guidelines for use by professionals attempting to provide high quality care. The papers in part I are concerned with the various constituencies for child care: the needs of particular groups within the population, what is being done to meet those needs, and what is required to close the considerable gap between the need and the supply of services. Included is a consideration of parents' needs for information and how these needs can be met in the child care setting. Part II reviews the current state of support for child care. Papers in this section report on the progress that is being made at the governmental level, in the private sector, and among the public at large. The papers in part III are all involved with the nature of child care: the various forms in which it appears, the ways in which it interacts with other disciplines in providing comprehensive services to the children in child care, the features that constitute quality, and ways of helping child care providers achieve quality. The implications for training in various disciplines are an important focus of this group of papers. Guidelines for action are appended. (RH)

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Group Care for Young Children

**Considerations for Child Care and
Health Professionals, Public Policy
Makers, and Parents**

Edited by Nina Gunzenhauser
and Bettye M. Caldwell, Ph.D.

Introduction by Bettye M. Caldwell, Ph.D.

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Edited by Nina Gunzenhauser and
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GROUP CARE FOR YOUNG CHILDREN

**Considerations for Child Care and
Health Professionals, Public Policy Makers,
and Parents**

**Edited by
Nina Gunzenhauser
and
Bettye M. Caldwell, Ph.D.**

**Introduction by
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To David Belais Friedman, M.D., F.A.A.P.

(1916 - 1985)

This volume is dedicated to Dr. David Belais Friedman, who was to have been a participant in this Pediatric Round Table. Throughout his long and distinguished career, Dr. Friedman helped hundreds of residents appreciate the importance of Child Development as part of the knowledge base for their specialty. At various times he served as Chairman of the Child Development Section of the American Academy of Pediatrics and as a member of the Academy's Committee on Psycho-Social Issues and the Family. During his career he helped develop many national programs devoted to the prevention of child abuse and neglect. In this context, he recognized the importance of child care as a support service to families in distress and helped formulate standards which would be conducive to high quality in such programs and in those for all children. With the collaboration of his wife, Alma, he wrote several papers pertaining to family development, child care, and the dilemmas of child abuse. We are honored to be able to publish in this volume Dr. Friedman's last paper.

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PARTICIPANTS

Susan S. Aronson, M.D.

Clinical Associate
Professor of Pediatrics
Hahnemann University
Clinical Associate
Professor of Community and
Preventive Medicine
Medical College of Pennsylvania
605 Moreno Road
Narberth, Pennsylvania 19072

Helen Blank

Children's Defense Fund
122 "C" Street, N.W., 4th Floor
Washington, D.C. 20001

Bettye M. Caldwell, Ph.D.

Donaghey Professor of Education
College of Education
Center for Child Development
and Education
University of Arkansas
33rd and University Avenue
Little Rock, Arkansas 72204

Rebecca R. Fewell, Ph.D.

Professor of Education
Special Education
University of Washington
Experimental Education Unit, WJ-10
Seattle, Washington 98195

Juanita W. Fleming, R.N., Ph.D.

Professor and Associate Vice
Chancellor for Academic Affairs
Medical Center
University of Kentucky
Lexington, Kentucky 40536-0232

Dana E. Friedman, Ed.D.

Senior Research Associate
Work and Family Information Center
The Conference Board
845 Third Avenue
New York, New York 10022

Ellen Galinsky, M.S.

Project Director
Work and Family Life Studies
Research Division
Bank Street College of Education
610 West 112th Street
New York, New York 10025

Elinor Guggenheimer

President
Child Care Action Campaign
99 Hudson Street, Room 1233
New York, New York 10013

Nina Gunzenhauser

Science Writer
Gladstone Hollow Road
Andes, New York 13731

Susanne Martinez, J.D.

Legislative Assistant
c/o Senator Alan Cranston
112 Hart Senate Office Building
Washington, D.C. 20510

Judith S. Palfrey, M.D.

Chief, Division of Ambulatory Medicine
The Children's Hospital
300 Longwood Avenue
Boston, Massachusetts 02115

Bonnie J. Petrauskas

Professional Relations
Johnson & Johnson Baby Products
Company
Grandview Road
Skillman, New Jersey 08558

Robert B. Rock, Jr., M.A., M.P.A.

Director of Professional Relations
Johnson & Johnson Baby Products
Company
Grandview Road
Skillman, New Jersey 08558

Sandra Scarr, Ph.D.

Commonwealth Professor of Psychology
Chair, Psychology Department
University of Virginia
102 Gilmer Hall
Charlottesville, Virginia 22901

Marilyn M. Smith, Ed.D.

Executive Director
National Association for the
Education of Young Children
1834 Connecticut Avenue, N.W.
Washington, D.C. 20009

Margaret D. Wishart

Deputy Administrator and Manager
of Prison Health Services
Montefiore Medical Center
Montefiore-Rikers Island
Health Services
15-15 Hazen Street
E. Elmhurst, New York 11370

Michael W. Yogman, M.D.

Assistant Professor of Pediatrics
Harvard Medical School
Director, Infant Health and
Development Program
300 Longwood Avenue
Boston, Massachusetts 02115

Preface

When *Group Care for Young Children* was proposed as the subject for a Johnson & Johnson Pediatric Round Table, there was no question about its timeliness. We had become increasingly aware of the rapid growth in the number of mothers in the labor force and the resulting increase in the need for quality child care for these working mothers. And, considered in the light of our community responsibilities expressed in our corporate credo, the subject was highly compatible with one of our principal objectives — i.e., to provide an educational resource facility on child health and development. Given this combination of factors, we felt we could use this Round Table to make a comprehensive contribution to the body of significant information available for use by child care and health professionals, public policy makers, and parents.

Our choice of Bettye Caldwell, Ph.D., as Round Table Moderator was both carefully calculated and fortuitous. Through her good offices we assembled a distinguished faculty whose talents ran across the board from medicine and academia to industry and parents and consumers. Their broad-based knowledge and experience in the field have provided valuable insights into the primary issues and areas for consideration.

Just recently Dr. Caldwell wrote a very persuasive paper on "Effective Marketing of Quality Child Care" (Caldwell & Boyd, 1984). The thrust of the Round Table, together with its Guidelines for Action, carries forward this concept of marketing the spectrum of child care subjects in terms of goals and action programs.

We feel that readers of this publication will come away from it with a heightened awareness of the meaning of key terms essential to the concept, such as *professional child care*, *comprehensive*, *quality*, *growth-fostering environment*, *child-rearing system*, *continuum of services*, and *supplement to rather than substitute for parental care*. With this knowledge they will be able both to seek out and to contribute to the continuum of high quality child care services.

Robert B. Rock, Jr., M.A., M.P.A.
Director of Professional Relations

INTRODUCTION

If an anthropologist from another planet came to Earth today and wrote up a typical ethnographic description of child-rearing on almost any part of the planet, the narrative would have to read something like this:

The children are reared partly in their homes and partly in little enclaves of children of approximately the same age. Some of these enclaves are very small, only four or five children. Some are medium-sized, thirty or forty children. Some are huge, 150 to 200 children. As the children address the adults rather formally, they are apparently not related to them. The children spend a significant part of their time in these centers, and a great deal of the teaching and learning that transpires during the early years takes place in those settings.

Certainly we would have to describe child-rearing in America in such terms. Today more than 50 percent of children younger than six spend significant portions of their lives in some type of child care. Thus child care obviously makes an important contribution to the socialization of children into the mores and values of the culture and deserves as much attention as other social systems such as the family, the educational system, the church, and the political system.

This Round Table was convened with several objectives. The first was to reconceptualize child care, to position it as part of the child-rearing system — a supplement to, rather than a substitute for, parental care. The terminology of child care tends to trivialize the service in many ways and to minimize its role in the lives of children. The most commonly used synonym for the field is still *baby-sitting*, a term that hardly implies a professional service of consequence in the lives of children. A major goal of the Round Table was therefore to *de-trivialize* child care.

A second objective was to advance the concept of child care as representing a continuum of services that virtually all families will utilize at some time to some extent and to advocate for the development of a diversity of services that can meet the needs of all children and families. Children are not either "raised in day care" or "raised at home." Most children spend time in both settings, although the balance between the two settings varies from child to child. Just as

different families need service for differing lengths of time, so must there be available a continuum of services that can match the needs of all families.

Recognition of this continuum does away with another semantic confusion that has plagued the field — the distinction between early childhood education and day care. The former type of program has traditionally operated for shorter hours and presumably (though not actually) had different goals. And to many people the two fields connoted different levels of quality: early childhood education is good for young children, but day care is bad; early education uses trained people, day care whoever can be hired; families are involved in early childhood education but not in day care — and so on. Essentially the two fields are isomorphic except for the factor of length of operating day, and even that is not always different. They represent quantitative points along a comprehensive child care continuum.

The third objective was one of particular interest to Johnson & Johnson: to establish the role of health care professionals in the design and implementation of quality child care. The first and most fundamental task for any child care program is to create and maintain healthful conditions, and the child care movement could not have occurred without some of the recent advances in medical science. Prior to the availability of the Salk and Sabin vaccines, it was not safe to put very young children together in groups. Now it can be done, provided that health care professionals carefully monitor conditions. An important objective of the Round Table was to strengthen their role in child care programs.

Achieving quality child care is a Sisyphean task. You get close to the top of the hill, and suddenly you are back down at the bottom. We survived the accusations of "family-weakening" and "communizing" and were making progress in gaining public acceptance when out of the blue came accusations of sexual abuse in centers in several areas of the country, and we were back at the bottom of the hill again. The fourth objective of the Round Table was to develop a set of guidelines for use by professionals directed toward achieving quality child care.

The group convened at the Round Table to address these objectives represented a wide variety of professional interests. Their papers and their discussions therefore present a rich, multifaceted exploration of the entire field of child care.

The papers in part I are concerned with the various constituencies for child care: the needs of particular groups within the population, what is being done to meet those needs, and what is required to close the considerable gap between the need and the supply of services.

Included in this group is a consideration of parents' needs for information and how these needs can be met in the child care setting.

Part II reviews the current state of support for child care. There are those who despair that this country will ever have anything like a coherent national child care policy, but fortunately there are also those who refuse to despair and continue to work toward such a policy. The papers in this section report on the progress that is being made at the governmental level, in the private sector, and among the public at large.

The papers in part III are all involved with the nature of child care itself: the various forms in which it appears, the ways in which it interacts with other disciplines in providing comprehensive services to the children in child care, the features that make for quality, and ways of helping child care providers achieve that quality. The implications for training in various disciplines are an important focus of this group of papers.

Following the presentation and discussion of the individual papers, the participants in the Round Table together addressed the development of the guidelines described as the fourth objective. The results of their efforts are contained in the appendix.

Bettye M. Caldwell, Ph.D.

PART I
THE CONSTITUENCIES
FOR CHILD CARE

PROFESSIONAL CHILD CARE: A SUPPLEMENT TO PARENTAL CARE

Bettye M. Caldwell, Ph.D.

When children spend part of their time in group care during their early years, the responsibilities and opportunities of parents are no different from those of parents whose children are at home full-time. Children who are enrolled in different types of group child care programs are still being reared primarily by their own parents. Child care provided by someone other than a nuclear parent supplements the care received from parents but in no way substitutes for it. Professional child care is part of the overall child-rearing system, and all children are likely to be exposed to this system to a lesser or greater extent.

This paper discusses the relationship between the roles of the family and of professional caregivers in child-rearing. It discusses popular misconceptions about child care, including the false dichotomy between early childhood education and child care, and offers a new definition of child care. The paper concludes with a set of recommendations for action that are needed to ensure that child care can fulfill its potential role in the child-rearing system.

Child-Rearing and the Family

Throughout history, in all societies for which we have any records, the major child-rearing functions during the early years of life have been assigned to the family unit. As is now documented in a wealth of ethnographic reports (see Werner, 1979), there is considerable diversity in the handling of that assignment, in the specific roles given to different family members, and even in who may and may not be designated as part of the family. Likewise, the values associated with different terminal (i.e., adult) behaviors and the techniques used to achieve those behaviors will vary widely from one culture to another. Nonetheless, every society has its own acceptable norms about what constitutes an acceptable family unit and how it will perform its child-rearing tasks. Ours is no exception.

We have generally assumed that the family will consist of a father, a mother, and one or more children. We have also assumed that it may include one or more additional adults from the previous or present generation with blood ties to one of the parents — i.e., that it may be an extended rather than a nuclear family. If all these principal characters in the family scenario are present, and if societal resources and circumstances allow physical needs to be met, we have assumed that the family, nuclear and/or extended, can meet the psychological needs of the children who become part of the unit. Although historical descriptions of severe punishment, abandonment, mutilation, and other atrocities (see Rosenheim, 1973) carried out under the banner of family rights might occasionally make us wonder, it has not been a bad assumption.

What is at question is whether, if the cast of the family scenario changes, or if people in the cast choose to play roles that differ from what contemporary Western society considers traditional, the needs of children can still be met. For example, if there is no father available both to produce income and to participate in the socialization of the children, how will the children be affected? And if the mother works outside the home as well as inside, how will her absence affect the style of child-rearing to which the children are exposed? Or what happens if the cast changes frequently, with one person playing the role of father or mother for a time and then leaving, with or without another person immediately available as a replacement? Such scenario changes are commonplace in today's world (Bureau of Census, 1982; Bureau of Labor Statistics, 1985), as a few statistics will attest:

- Close to two-thirds (62.1 percent) of all mothers with children under eighteen are in the labor force.
- Fewer than one-third of children whose mothers work full-time are cared for in their homes.
- Roughly one in three new marriages will end in divorce within five years.
- One out of every five American children lives in poverty; for black children, that figure is one out of every two children, and for Hispanic children one out of three.
- More than twelve million children (20 percent) live with their mothers only; 50 percent of all black children live with their mothers only.
- Approximately one birth in five is to an unmarried woman.

Such demographics have produced alarm reactions about family life and have raised questions about whether the needs of young children can be adequately met in such settings. Data from studies of the effects of divorce on children (Wallerstein & Kelly, 1979; Hetherington, Cox, & Cox, 1978) are showing more negative sequelae than had long been presumed to exist. Child abuse is often referred to as "a national disgrace," with estimates of the number of children abused each year ranging up to one million. Sexual abuse, a subcategory of child abuse, also has an alarmingly high incidence, and the National Committee for the Prevention of Child Abuse estimates that over 90 percent of the alleged offenders are relatives or close friends. Thus in many ways it is possible that the family is not the setting for fulfillment and tranquility that it is sometimes represented to be and that the parenting provided therein may not by itself enable children to develop optimally.

Child-Rearing and Professional Child Care

These demographics and the alarm reaction they have generated have also produced an intensification of interest in ways in which parental care can be supplemented by individuals or groups outside the family. Without fanfare, and without a public policy that puts the imprimatur of acceptance on such a service, professional child care has risen to a high level of public consciousness as the vehicle through which such supplementation can be provided. This new visibility has

led more and more people and groups to ask the same question that is being raised about the family — namely, whether the needs of children can be met in such a setting.

It is good that both questions should be asked, although each implies a certain misunderstanding of past and present social realities. To raise the question about the contemporary family ignores the significant amount of family upheaval that has occurred throughout history. Yet, as Bane (1976) has reminded us, the family appears to be here to stay. To raise the question about whether extra-family child care might possibly be inimical to optimal child development overlooks the extent to which someone other than the mother has provided significant amounts of care for young children throughout history (Aries, 1962). Furthermore, an alarmist position represents a misunderstanding not only of the extent to which such care is a basic and necessary component of the child-rearing system but also of the potential of such care to augment family life in significant ways.

Because of the family and societal realities described earlier, supplementary child care several hours each day for perhaps five or six days per week is now necessary for approximately half the young children in this country. But even for those children whose mothers are not employed in the work force, intermittent care by someone other than an immediate family member is generally utilized for several hours a week. For upper-income families it may be used to enable mothers to do volunteer work in the community or to participate in recreational activities. For lower-income or welfare families it may occur while the mother is looking for employment or during times of illness or family crisis. We do not customarily think of children in these latter groups as "being in child care," but indeed they are.

These social realities remind us that a significant part of the socialization of children takes place in child-rearing settings other than the immediate family and that child care functions as a subsystem of the broader child-rearing system — the subsystem outside the family likely to be the first to reach the child and to have more hours and days of influence than any other (with the possible exception of the mass media, mainly television).

Misconceptions About Child Care

In view of the importance of child care for the socialization of children, and in view of the fact that most children will come in contact

with the system for a significant amount of time during their early formative years, one would think that the service would be accorded high status by the general public. However, this does not appear to be the case. Tocsins are frequently sounded about adverse consequences associated with enrollment of a child, particularly one younger than three, in child care of any type. Recent exposés of sexual abuse in such settings have caused general public alarm. Workers in the field receive piteously low salaries and perceive themselves as having little appreciation as professionals who make important contributions to the well-being of children and families.

The failure of the public to appreciate the importance of supplementary child care as a vital component of the child-rearing system is an unfortunate consequence of the modern history of the field in America and of the lack of conceptual clarity found in either the language of professional/scientific writing or of everyday discourse. Elsewhere (Caldwell, 1983) I have discussed some of the misconceptions of the service which have adversely influenced public opinion about the field. One perfectly valid reason for such misconceptions is the fact that professionals themselves have not been consistent in defining the service for the public. A first area of confusion comes with the designation of the service itself. Is it *day care* or *child care*? Both in writing and in speaking I deliberately shift back and forth between these terms in order to make it absolutely clear that I am using them interchangeably. *Child care* appears gradually to be taking over; certainly it is in greater use internationally than the term *day care*.

But in addition to the semantic confusion associated with the generic label for the field, we have also allowed an inaccurate concept to develop by carelessly allowing misleading terms to be offered as synonyms. Anytime we use a term like *baby-sitting* as a synonym for child care, we are trivializing the field, and when we do not protest against such terms as *custodial care* or *institutional care*, we are essentially allowing the field to be libeled. In an earlier era we also frightened away potential supporters by implying that the service was needed primarily by families with a high degree of social pathology. But, if one was needed, the *coup de grace* to public acceptance of professional child care was the characterization of it as "communal care," than which there could be nothing more un-American!

A final semantic adjustment that has to be made is the eradication of the false dichotomy between early childhood education and child care. I do not suggest that there were never any legitimate distinctions between the areas. The two fields had their origins under different auspices — child development for early education and social welfare

for child care. Likewise, they may well have had slightly different goals — enhancement of development for early education and care and protection for child care. And to some extent they seemed to identify their clients differently. Child care operated within a social service orientation; the mother was the client. In early education programs, the client was the child. But the two fields have not been developing on parallel tracks; rather, they have been on converging tracks that because of modern demographic realities have now merged. The resulting service is both educational and protective, and the client is the family unit.

Perhaps the most basic misconception we have about child care is that it is a *substitute* for rather than a *supplement* to family care. This thinking can be seen, for example, in the designation for samples in child care research; almost invariably the groups will be labeled something like "Home-Reared Subjects" and "Day Care Subjects." Such labels imply that child care is either *used* or *not used* by a given family, that children are either home-reared or reared in day care. This assumption is false on at least two counts: first, that there are children who do not experience extra-family child care, and second, that children who have some extra-family child care are not primarily home-reared. Virtually every child experiences some degree of extra-family care. Similarly, short of foster home placement, all children who receive child care services are still being reared primarily by their own families.

A Contemporary Concept of Child Care

We have now, I believe, reached the stage at which professionals who help to establish public attitudes and to give direction to service patterns can endorse and disseminate a more accurate conception of child care. I have presumed to formulate just such a definition, one that takes into consideration modern family demographics and at the same time moves away from stereotyped thinking about what child care is and is not. It is far too long a definition to be suitable for a dictionary, but just as the service itself is complex and comprehensive, so should be its definition:

Professional child care is a comprehensive service to children and families which supplements the care children receive from their families. It is in no way a substitute for

parental care nor a competitor for the role of parents in the upbringing of their children. Virtually all children are reared primarily in their own homes by their own families, and virtually all children receive some degree of supplemental care from persons other than their parents.

The need for professional child care varies quantitatively as a function of demographic characteristics of the family. Families in which the primary caregiver works outside the home as well as inside because of choice or economic need, and families in which the major caregiver has a disability which interferes with child-rearing, need relatively more supplementary care. Families in which there are two parents and clear role differentiation relative to income production and household services may need and utilize the professional child care system only intermittently. Nonetheless, rare indeed would be the family that never needed or used the system.

Professional child care programs can and do vary in quality, just as family experiences can and do vary in quality. Quality varies as a function of the characteristics and training of the people who provide the service, the physical setting in which it is provided, and the support for such services provided by the society at large. Regardless of the extent to which families need to participate in the child care subsystem, all families need and are entitled to services of high quality. It is possible to identify those factors associated with quality and to advocate for their availability and the removal or improvement of services that do not possess attributes of quality.

Just as the child-rearing system must be concerned with all aspects of a child's development, so must any service that is part of that system deal with the whole child. Thus professional child care must foster the development of the child physically, intellectually, and socio-emotionally. Such services must have as an overall goal the creation of a growth-fostering environment that meets the needs of both children who are developmentally sound and those who are at risk for or clearly possess developmental problems. In this task there must be close coordination with the children's parents in terms of developmental goals and strategies by which these goals are achieved. Input from representatives of all disciplines concerned with child development is

essential if comprehensive programs representing high quality in all components of the service are to be available.

Differences in types of services needed by children from different family settings are more a matter of degree than of kind. Those who design and provide professional child care services have a responsibility to provide a continuum of high quality services that will appropriately match the needs of children and their families.

A long definition, to be sure, but most of the words were essential to cover the concept, especially *professional child care*, *comprehensive*, *subsystem*, *child-rearing system*, *supplement*, *varies quantitatively*, *quality*, *growth-fostering environment*, and *continuum*. It is my fervent hope that, in the future, whenever people think about child care and what it means, most of or all those terms will somehow come to mind.

Sharing the Care

From this conceptualization of child care as a responsibility that professionals share with rather than usurp from parents, one can derive a number of recommendations for action which will increase the likelihood that professional child care can augment parental care.

1. Quality child care must be made available for *all* children.
2. Child care settings should be used for the delivery of other crucial services.
3. We must develop a consistent and coherent public policy regarding child care and persuade the public of its importance.
4. We must involve the private sector in planning for and in providing child care services.
5. We must keep open our options for ways of providing child care.
6. We must provide training for a variety of roles in child care for professionals in different disciplines.
7. We must promote vigilance in the area of health maintenance in child care.
8. We must work for high quality in child care.

DISCUSSION

Dana Friedman: In the last part of your definition of child care, you say that professionals in child care have the responsibility of providing a continuum of high quality services. That would imply to me that if they failed at that, it would be their fault, when in fact it's society's responsibility. The professionals are never given the resources to provide the quality.

Betty Caldwell: Maybe what I meant to say there is that society has the responsibility to see to it that the professionals who design and implement services can indeed provide a continuum. Some centers will not allow parents to enroll their children part-time, because they can't work things out financially if they do. And such policies make a mockery of the concept of a continuum.

Elinor Guggenheimer: It seems to me that one of the goals in society is to have everyone in that society aware of what children's needs are in order to build the next generations. Will those generations be able to continue the goals of the society they happen to be born into? What bothers me is the idea that certain people are supposed to know a great deal about child care but that the vast public probably does not need to know a lot about it. A great many people come in contact with any one child in that child's lifetime, and one of the problems we have with some of the people in the corporate world, for instance, is that they don't feel it's very important for them to have a background of knowledge about child-rearing because that's somebody else's problem.

The goal of education, it seems to me, should be to educate everyone about what the next generation should be receiving, whether they are going to be working directly with the next generation in a formal setting or in informal contacts or whether they are going to be the ones who set the broad societal policies that build the child care programs.

Susan Aronson: There is a lot of opposition in this country to the need for professionalization of child care. Child care is considered just a natural thing, the task that has always been relegated to women. Somehow we need to capture what is different about this time and age in our belief that it requires professional expertise to help parents to learn. What is different about the absence of the extended family experience? What is different about the technical nature of so much of what we believe is important to child-rearing? Why do parents need to be taught about health and sanitation and child development, when they seem to have managed to raise children for generation upon

generation without that knowledge? We have a job to do, not just in selling the need for child care and for the professionalization of child care but in helping the public at large understand why child-rearing is not purely innate and why it requires some involvement of professionals to help them raise healthy, productive, and successful members — and happy members — of our modern society.

Rebecca Fewell: These new definitions of day care, of group care, of a service continuum, of a supplement, seem to be expressing the changing needs of care for this day and time. I think we are trying to grasp a definition or definitions that will speak to where we are in the 1980s. Maybe it will be some consolation to know that forty years from now, they will be struggling with our definitions and saying, "How could they have described it in this way?" because the needs will be different then.

Betty Caldwell: I agree. It surely seems that somebody will come up with a better term. I am trying to work up a plan of action to push for the term *educare*. We are ready for some such term that does a better job of expressing what we are talking about. If we move from concepts to labels that are better, it might help.

Helen Blank: I am a little concerned about the label. There is obviously a big struggle going on in schools looking to a two-and-a-half-hour day with the preschool movement. I'm concerned about how you would expand the definition of education for four-year-olds to be more comprehensive, to talk about the other facets of child care. If we called it *educare*, we might seem to be supporting the more limited program.

Betty Caldwell: My thought is that it would be just the reverse. If you change the *t* to *r*, it's not just education; you are getting the word *care* into it. But it's hard to know. The only label changes that I've actually seen in my time are a gradual shift from *caretaker* to *caregiver* and from *day care* to *child care*.

Juanita Fleming: I think we should be looking at child care not just from the perspective of early childhood. Our message to the public will have greater impact if we look not only at early childhood but at school-age children, too, on an age continuum.

Betty Caldwell: Right, I can see areas where the continuum is not adequately covered. It certainly should mention age.

Elinor Guggenheimer: We have been using the word *continuum* a great deal lately in our Child Care Action Campaign to mean

something different from your usage. It is our term for the linkages between existing programs. One of the problems we keep seeing is that a parent who goes back to work when his or her child is three months old will need care over a long period of time and will probably have to look for that care repeatedly, in an agonizing kind of search. You are going to have to give me a new term to mean the linkages between different kinds of programs, a system of patterns in which people go from one program to another.

CONTEMPORARY PATTERNS OF CHILD CARE

Ellen Galinsky, M.S.

The number of working mothers has increased dramatically in recent years, yet the data on where and how American children are cared for while their parents work are fragmented and incomplete. This paper reviews current and projected figures for mothers in the labor force, suggesting that there is a considerable gap between supply of and demand for child care. The paper discusses the problems of providing adequate and affordable care for children as sources of parental stress and their differential effects on men and women. Negative public attitudes toward child care are shown to extend even into the child care world, and the reasons for the tensions between child care providers and parents are considered.

Labor Force Participation by Mothers

The increase in the number of working mothers is tantamount to a revolution (Smith, 1979). Table 1 shows the percentage of women with children under 18 who were in the labor force in March 1985. The percentage of working mothers with children under three jumped from

Table 1. Mothers in the Labor Force, March, 1985

	Total Number (thousands)	Number in Labor Force (thousands)	Percent in Labor Force
Women living with			
children under 18	32,295	20,041	62.1
Children 6 - 17	16,929	11,826	69.9
Children under 6	15,366	8,215	53.5
Married women with			
children under 18	24,566	14,932	60.8
Children 6 - 17	12,577	8,526	67.8
Children under 6	11,989	6,406	53.4
Children 3 - 5	4,478	2,616	58.4
Children under 3	7,511	3,790	50.5

Source: Bureau of Labor Statistics (1985)

35 percent in 1976, to 41 percent in 1979, to 50.5 percent in 1985 (Kammerman & Kahn, 1981; Select Committee on Children, Youth, and Families, 1984b; Bureau of Labor Statistics, 1985).

These trends are projected to continue. According to the Select Committee on Children, Youth, and Families (1984b) and the Bureau of Census (1984):

- Currently 80 percent of all women in the work force are of child-bearing age, and 93 percent of them are expected to become pregnant sometime during their working lives.
- By 1990, 66 percent of all new entrants into the labor force will be women.
- By 1990, 64 percent of all families with children will have mothers in the work force.
- By 1990, there will be 23 million children under six and 38 million children under ten.
- By 1990, there will be nearly three million more children under ten who will live in single-parent homes — a 48 percent increase in this decade.

Child Care Arrangements

As the Children's Defense Fund (1982b) has pointed out, we do not really know who is caring for the children of America. In the latest national child care survey, conducted by the Bureau of Census in 1982, parents were asked to list the primary form of care they used for the youngest child under five. Marx (1985) compiled this information to reflect the changes since 1958 (Table 2).

The most dramatic trend relates to care provided in the child's home, which decreased from 47 percent in 1965 to 31 percent in 1982.

Table 2. Child Care Arrangements of Working Mothers, 1958 - 1982

Arrangement	1982 %	1977 ^a %	1965 ^b %	1958 ^b %
Care in home^c				
Total	31	32	47	NA
Employed full-time	26	27	47	57
Employed part-time	39	40	47	NA
Care out of home				
Total	40	40	31	NA
Employed full-time	44	46	37	27
Employed part-time	35	29	17 ^d	NA
Relative care				
Total	44	42	46	NA
Employed full-time	40	42	46	51
Employed part-time	49	47	46	NA
Nonrelative care				
Total	28	30	31	NA
Employed full-time	29	33	38	33
Employed part-time	25	26	18 ^d	NA
Group care				
Total	15	13	6	NA
Employed full-time	19	14	8	5
Employed part-time	8	9	3	NA

NA = not available.

^a Includes care for youngest child under age 5.

^b Includes care for children under age 6.

^c Includes paternal care, but excludes maternal care while working.

^d Other arrangements accounted for 33 percent of all child care.

Source: Bureau of Census (1982, 1983)

Table 3 reflects the differences in the arrangements used by married and single mothers working full-time in 1982.

The low usage of group programs, at least as the primary form of care, probably reflects the fact that this survey was conducted in June, when kindergartens and nursery schools may be closed. It is clear, however, that intact families are less likely to use group care. The use of relative care (excluding fathers) was more important to single mothers than to married mothers (26.9 percent). If one includes fathers, however, then relative care is higher for married women (43.7 percent) than for single mothers (41.9 percent).

In contrast are data from the National Center for Educational Statistics. Between 1970 and 1983, preschool enrollment increased from 37.5 percent to 52.8 percent. When nursery school and kindergarten are considered separately, nursery school enrollment

Table 3. Child Care Arrangements of Employed Mothers
(Age 18 - 44) with Children Under Age 5, 1982

Arrangement	Married (N = 4,093,000)	Unmarried (N = 993,000)
	%	%
Care in own home		
Father	16.8	1.9
Grandparent	4.4	12.3
Other relative	4.4	8.7
Nonrelative	4.8	8.7
Care in other's home		
Grandparent	11.5	10.6
Other relative	6.6	8.4
Nonrelative	22.7	19.2
Group care center		
Nursery school	4.8	8.6
Day care and all other	8.6	11.7
Mother cares for child while working	10.5	3.3
Miscellaneous	.1	.5
No answer	4.9	6.1

Source: Bureau of Census (1983)

doubled, from 15.3 percent to 33.6 percent, and kindergarten enrollment increased from 80 percent to 93 percent of the five-year-olds (Papageorgiou, 1986). Kamerman (1983) calculates that almost two-thirds of all three- to five-year-olds and 70 percent of those with working mothers are in some form of group care. The higher the mother's education and income, the more likely the children are to be in nursery school, while lower-income and minority children are more likely to be in day care (Coelen, Glantz, & Calore, 1979). Looking just at out-of-home care, Marx (1985) estimates that 3.9 out of 4.5 million three- to five-year-olds with employed mothers (over 85 percent) are in group or family day care.

We know even less about arrangements for infants and toddlers. According to Kamerman (1983), one-third of all children with mothers working full-time and 17 percent with mothers working part-time were in family day care in 1977; 9 percent of children under three with mothers working full-time were in group care. The remainder were presumably cared for by mothers on maternity leave, by parents with shift work schedules, and by others in the home.

No one knows how many programs exist for school-age children, but Seligson of the School-Age Child Care Program at Wellesley College thinks there are many thousand ("After-hours child care: Schools' new worry," *New York Times*, 16 Sept., 1985).

In summarizing the known child care arrangements and comparing them against the known number of working mothers, the Children's Defense Fund (1982) concluded that "only 54 percent of American children of parents employed full-time have identifiable child care arrangements" (p. 8).

In the absence of national data, several local studies have been conducted. The most extensive was done by Emlen and Koren (1984) of 8,121 employees in Portland, Oregon. They found that 50 percent of male employees with children under twelve used care at home (corresponding perhaps to the fact that only 52 percent of the male parents had employed spouses). Sixteen percent of the women employees used in-home care. Out-of-home care was used by 35 percent of the men and 56 percent of the women in a ratio of 4:2:1 for family day care, centers, and relatives. Self- and sibling care was used by 15 percent of the men and 28 percent of the women.

Fernandez (1985) conducted a survey of 5,000 employees in five companies. He found that 37 percent of married women used family day care as their primary kind of care. His figures for self-care are close to those of Emlen and Koren: 29 percent for single women, dropping to 20 percent for married women, 35 percent for single men,

and 19 percent for married men. Shinn and Wong (1985) found 15 percent of their sample of 651 employees in the New York area using self-care. In several studies (Fernandez, 1985; Shinn & Wong, 1985) parents reported using care by children with children over ten, but Emlen and Koren (1984) found that 25 percent of the self- or sibling care arrangements were for children under six and that 6 percent were for children under two. A poll by *Working Woman* reported that one-third of the eight-year-olds and half of the nine-year-olds spent time in self-care (Burtman, 1984). In our work with a blue-collar population (Galinsky & Love, 1985) we see a similar pattern.

Emlen and Koren found that the level of income does not predict the use of self- or sibling care. Shinn and Wong (1985) also found that education, income, marital status, and employment status did not determine the use of this kind of care.

Supply and Demand in Child Care

Is there a gap between the supply of and the demand for child care? In a recent study of the employees of a hospital, Emlen and Koren (1985) report that 75 percent of the women and 57 percent of the men found it difficult to find child care. Resource and referral agencies consistently report that the supply of child care is not sufficient. There are often long waiting lists for infant/toddler care programs and providers as well as for after-school care.

If one rephrases the question to include "affordable" care, the answer is certainly yes. Despite the fact that the media continue to portray the working woman as living in a \$100,000 house and working to buy luxury items, the Select Committee on Children, Youth, and Families (1984b) reports that 25 percent of the married women in the labor force have husbands who earn less than \$10,000 per year; 50 percent are married to men earning less than \$20,000; and nearly 80 percent are married to men with incomes under \$30,000.

Child Care Dissatisfaction, Parental Stress, and Absenteeism

It is complicated to ask parents if they are satisfied with the child care they are currently using. For parents to admit dissatisfaction, they have to admit that they don't like what they are doing with their

children. The workers seemingly most ready to express negative or ambivalent feelings are those who rely on self- and sibling care. Emlen and Koren (1984) report that 57 percent of these employees express some dissatisfaction; 64 percent of them reported difficulty in finding child care.

Another way of approaching the issue is to ask parents about how they manage work and family responsibilities. In our corporate study at Bank Street (Galinsky, Hughes, & Shinn, 1985), one-third of the employees in our sample said it was "difficult" and 41 percent reported that work and family responsibilities interfered with each other. In a regression analysis the sex of the worker was not predictive of work/family interference, in contrast to the Portland study (Emlen & Koren, 1984), in which 47 percent of the women and 28 percent of the men with children under twelve reported some child care stress in the previous four weeks.

An issue of considerable concern is the impact of various kinds of child care on productivity. While no studies have investigated productivity *per se* (that will be one of the contributions of the Bank Street study), studies have examined absenteeism and unproductive work time. Emlen and Koren's findings are shown in Table 4.

Women clearly are the most affected. The one exception is when families rely on their children to care for themselves or each other; then men and women lose a comparable number of days. Shinn and Wong (1985) also report that employed women miss work because of their child care responsibilities at rates twice those of men with employed wives and four times those of men with wives at home.

Studies such as those by Kamerman (1980) have shown that parents use different arrangements for different children at different times of the day and on different days of the week. Shinn and Wong (1985) have found that when parents have many arrangements, these arrangements are more likely to break down, and this is one of the biggest predictors of stress. The degree of flexibility in the arrangements is a source of satisfaction or stress for working parents.

For women, a major source of stress is the disproportionate responsibility that they both want to and are expected to take in managing family affairs. Women do more child care and housework than men, with various studies reporting a range from two to six times as much (Carlson, 1984; Robinson, 1977; Slocum & Nye, 1976; Pleck, 1983). Women also retain the responsibility for overseeing family work (Barnett & Baruch, 1983).

Another source of stress is the care of sick children. The child care system may work for everyday situations but not for the care of sick

Table 4. Absenteeism by Type of Child Care

Parent	Arrangement	N	Average Days Missed Per Year
Men	Care by adult at home	614	7.9
Men	Care out of home	437	9.0
Men	Care by child	190	13.4
Women	Care by adult at home	189	9.3
Women	Care out of home	670	11.4
Women	Care by child	330	13.0

Parent	Arrangement	N	Average Times Late Per Year
Men	Care by adult at home	611	4.9
Men	Care out of home	437	6.9
Men	Care by child	188	8.3
Women	Care by adult at home	186	9.6
Women	Care out of home	665	15.8
Women	Care by child	329	18.5

Parent	Arrangement	N	Average Times Left Early Per Year
Men	Care by adult at home	610	7.8
Men	Care out of home	437	10.4
Men	Care by child	188	10.8
Women	Care by adult at home	189	8.9
Women	Care out of home	663	12.4
Women	Care by child	327	13.6

Parent	Arrangement	N	Average Times Interrupted Per Year
Men	Care by adult at home	606	25.3
Men	Care out of home	434	34.9
Men	Care by child	187	34.3
Women	Care by adult at home	183	29.8
Women	Care out of home	665	33.8
Women	Care by child	329	78.4

children. Fernandez (1985) found, for instance, that married women with children are more likely to miss work than men and that caring for a sick child was the cause of absenteeism for 56 percent of the

women who missed one to three days the previous year, 78 percent who missed four to six days, and 82 percent who missed more than six days.

Attitudes Toward Child Care

Even today, with 53.5 percent of the mothers of children under three years old in the work force (Bureau of Labor Statistics, 1985), the predominant attitude toward day care is negative. In a national survey conducted by the Public Agenda Foundation, a sizeable number of working mothers themselves disapproved of maternal employment. Forty-three percent of working mothers with children under twelve agreed that "when mothers of children under six work, it weakens the family"; 42 percent agreed that "having a mother who works is bad for children under six" (Kagan, 1983).

These attitudes exist even among child care providers, including the staff of the very best centers. In an informal survey I conducted of the entire staff of an excellent day care center, 78 percent agreed with the statement "It would be better for young children if their mothers didn't work." The attitudes about how the children will turn out, however, seemed quite favorable. Eighty-nine percent felt that young children do well if they are in good child care.

When it came to attitudes about the parents, more negative views appeared. Parents were seen as interested in their children but too tired to give them much attention. Only half the day care staff felt that parents spent quality time with their children. Fifty-seven percent thought that parents were competitive with child care providers, while 39 percent thought that child care providers were competitive with parents. A picture of tense relationships between parents and providers emerged, one that is borne out by my experience in working with both groups. Providers tell stories of mistrust, of a seeming lack of caring or appreciation. Parents are seen as primarily interested in three things: "What hours is the program open?" "How much does it cost?" and "Can I drop my child off tomorrow?" Parents, in turn, have complaints about providers. In early data from the Corporate Work and Family Life Study, when we asked parents about how much child care providers or teachers could be relied on when things got "too tough" in balancing work and family life, 25 percent said "a little" while 38 percent said "not at all" (Galinsky, Hughes, & Shinn, 1985).

We hope to continue to study what predicts providers' negative attitudes toward parents. The factors we plan to investigate are: (1) the

differential in income between parent and provider; (2) the child-centered versus family-centered focus of the provider; (3) the provider's work conditions; and (4) the way the provider is raising her own children.

Conclusion

In our investigation of exemplary child care, William Hooks and I found that it functions best when it serves as a so-called "extended family" to the parents (Galinsky & Hooks, 1977). Increasingly sophisticated research is distinguishing the nature of this kind of supportive relationship. For social support to have positive effects, there has to be give and take, what Julian Rappaport (1985) terms "mutuality." In my neighborhood, there is a family day care provider who has helped rear many of the children there. When parents are sick or hospitalized, she keeps the children overnight. When people need her, she is always there. Recently, her mother died. The parents in the neighborhood cooked for her; the children she had once cared for mowed her lawn and did household repairs. One of the grown children she had taken care of arranged a surprise 50th birthday party to which a hundred men, women, and children came. In a mutual relationship, individuals are receivers as well as givers.

DISCUSSION

Sandra Scarr: Ellen's lovely anecdote at the end points out something I've been pondering since Bettye brought it up, about professionalization in child care. It's really the antithesis of this anecdote. On the one hand there is the notion of "educare" and the melding of the early childhood establishment into the child care establishment, which do have separate histories and have in recent years — thanks to people like Bettye — come more and more together. Looking at it from a professional's point of view, there is still a lack of adequate provision for training for many caregivers and a lack of regulation and inspection in the system. We would like to see it expanded, and we would like these people not only to have training but to have the regard of the rest of the community for doing a professional job.

But from the point of view of parents, this may create some of the very conflicts that Ellen talks about in her paper. If caregivers have a

very child-centered professional attitude toward the nature of caregiving, they look down on parents. They can make parents feel as though they are not adequately equipped or knowledgeable enough to be good parents. To have that attitude toward parents is to strain the relationship that could exist between a neighborhood caregiver and people who are her peers. I think there is a real dilemma here: where do we want to go with child care?

Ellen Galinsky: Although they may be rare, I have seen supportive relationships exist between parents and providers. Such relationships were present in the exemplary programs that Bill Hooks and I investigated (Galinsky & Hooks, 1977). In those programs, the definition of the job of child care provider included being a support for families as well as a support for children. Unfortunately, little of the training of child care workers involves this kind of definition. In training people who take care of children, we have to consider the needs of parents.

Sandra Scarr: In your own data, in one of the best child care centers that you studied, close to 80 percent of the caregivers had rather negative attitudes about parents' motivation toward their children and the kind of care that parents provide for the children. Are they not trained personnel, who have not only early childhood education but a great deal of experience with providing care?

Ellen Galinsky: They are trained in early childhood education, but they're not trained in working with parents. And that's not an easy skill to obtain. It takes the ability to be able to switch perspectives, and the training has to be more than just book learning.

Elinor Guggenheimer: I think that's what worried me before about the use of the word *professional*. It's saying that there are two different languages, that the caregiver is talking some different language from the parent.

Betty Caldwell: The word that I originally had in that definition, rather than *professional*, was *extra-family child care*, but that is such an awkward term.

Elinor Guggenheimer: I taught in a child care center some years ago. I can remember the parents coming in. They were tired. They had worked hard. They had to get home and fix supper. Yet it was the only contact we had with the parents. I've often thought it would be good if we could have a grocery service attached to the child care program that would provide take-home food, to give parents some extra time to

spend talking with the caregivers. I think we need to talk about supporting women, supporting families, and thinking about what their needs are and what can be done for them aside from simply taking their children as though they were a separate package in parents' lives.

Bettye Caldwell: Bob Lurie's program in Summit, New Jersey, did that. They started selling take-home food one night a week, and then they changed it to every day.

Ellen Galinsky: We often had dinner for everyone at the child care center that I ran. We brought in Chinese food or something easy so that everyone could sit around at the end of the day, and it worked very well.

Michael Yogman: I echo your finding about the negative feelings of caregivers to child care. In the recruitment phase of our high-risk intervention project for premature infants in Boston, we had a very high refusal rate around day care issues for high-risk infants. Almost everyone that we attempted to recruit who had been a child care provider refused the program on that basis.

I think there's more to it than the intrinsic tension between parents and caregivers. I believe it is compounded with the low income that child care providers earn and their own feelings of fatigue and lack of gratification on the job. It reflects the devaluing that the providers themselves feel about what they are doing, which we need to take very seriously.

THE SPECIAL NEEDS OF SINGLE-PARENT AND LOW-INCOME FAMILIES

Helen Blank

Child care is a vital topic for low-income families and children. It is essential if mothers are to participate in training programs or in jobs that will allow them to move their families toward self-sufficiency. Supportive child care is also important to ensure that young children obtain the building blocks for a brighter future as productive adults. Programs such as Head Start have demonstrated that a high quality preschool experience helps children establish a foundation of intellectual, physical, social, and emotional well-being critical to their success as adults.

This paper discusses the dimensions of the need for child care among low-income and single-parent families. It describes the four essential components — health and nutrition, social services, education, and parental involvement — through which child care programs address the needs of the family as well as the child. Finally, it documents the results of the 1981 cuts in federal monies for child care and discusses their implications for the struggle of low-income families to become economically independent.

Benefits of Child Care for Low-Income Families

High quality child care is important to low-income and single-parent families for at least two reasons. First, it is essential if mothers are to participate in the labor force. A recent Bureau of Census survey (O'Connell & Rogers, 1983) asked women who were not in the labor force whether they would work if child care were available at reasonable cost. Forty-five percent of single women replied that they would, as did 36 percent of low-income women with family incomes under \$15,000. The U.S. Commission on Civil Rights (1981) notes that the inability to locate affordable child care restricts not only women's

employment and training opportunities but also their ability to participate in federally supported education programs. State and local studies (see, for example, Maine Child Care Task Force, 1984) confirm this finding. In Massachusetts, a mother described her situation as follows:

Things are very difficult for me financially right now, but I'm glad I have not lost my day care totally, as I thought I might at one point last year. I need day care so I can work and attend school. Even though the incentive is not there to work, I felt trapped in the welfare system. Day care has given me the freedom to get an education so that I can get employment and some day get totally out of the welfare system (Child Watch, 1982).

The number of families who need help in moving toward self-sufficiency is huge. According to the Select Committee for Children, Youth, and Families (1984a), over twelve million children live in single-parent families. By 1990 nearly one child in four will live in a single-parent household, double the 1970 rate. In these families, female heads of households are the principal source of support. When they work, they need help in meeting their child care costs. The average single mother with children earned only \$9,153 in 1983 (Bureau of Census, 1983). She would have had to pay almost one-third of her income (or \$3,000) to purchase center-based child care in most communities. This is three times as much as the 10 percent of income that is considered reasonable to pay for child care expenses.

Black children in female-headed families are the poorest in the nation. Half live in families with incomes below \$6,100. Between 1977 and 1982, the median income of these children's families dropped 28.3 percent (Bureau of Labor Statistics, 1977, 1982). Regardless of family type, black families earn significantly less than white families. The median family income of black families is less than 60 percent of that of white families. Half of all black families had incomes below \$14,500 in 1983 and thus need assistance to be able to afford supportive child care arrangements for their children (Bureau of Census, 1984).

Lack of child care may have contributed to the striking increase in the poverty rate of children under six. These children made up 37.4 percent of the overall increase in poor Americans from 1982 to 1983. For children under six, the poverty rate is over 25 percent — one out of every four children is poor. Among preschool children the poverty rate in 1983 in single-headed households was 68 percent (Bureau of

Census, 1984).

In addition to its economic benefits, child care helps children to become more productive adults. *Changed Lives*, a twenty-year follow-up study of graduates of a preschool program like Head Start, found that the total economic benefits for two years of quality preschool to the individual child and to society as a whole outweigh the costs by seven to one. Compared with their peers without a similar experience, preschool graduates were much more likely to graduate from high school and were less likely to be misclassified as mentally retarded or in need of special education. They did better on standardized achievement tests in reading, language, and math, and they were more likely to go on to vocational or academic training after high school (Berrueta-Clement et al., 1984).

The study also found that the advantages gained continue into adulthood. Those with preschool education are more likely to be working and to be satisfied with their jobs; they spend more time employed after graduation, and they have better paying jobs than their peers without the preschool experience. They are also less costly to society. They are much more likely to be supporting themselves and less likely to be receiving food stamps, Aid to Families with Dependent Children (AFDC), Medicaid, or general welfare assistance. Preschool graduates are less likely to be in trouble with the law and less likely to become teen-age parents than those without preschool education.

No Head Start or child care program is a magic bullet. The forces of poverty are exceedingly complex, and the path out of dependency is riddled with roadblocks and detours. By helping families through this maze, however, child care programs can at least provide a better beginning for children and a boost that may make a long-term difference for their families.

Goals of a Child Care Program for Low-Income Children

A comprehensive approach that responds to the needs of the whole child and the family is critical for child care programs serving low-income children. In order to thrive, a child must be healthy, well nourished, and loved and supported by parents who have control over their own daily lives. Four components of child care programs — health and nutrition, social services, education, and parent involvement — address family needs ranging from housing and health care to emotional support and family counseling.

Health and Nutrition. Children in low-income families are less likely to have a regular source of medical care, less likely to have received any medical care during the year, and much less likely to have received care from a private physician (U.S. Department of Health and Human Services, 1981a). Less than half the black preschool children are adequately immunized against diphtheria, pertussis, tetanus, and polio. Low-income children are more likely to live in inadequate, crowded housing with incomplete plumbing, characteristics that contribute to the spread of contagious disease and infection.

Obviously, a child with hearing problems, poor eyesight, or poor health in general cannot begin to take away the full benefits of a sound educational curriculum. A child care program can play a key role by screening children, ensuring that they are immunized and that they are provided necessary health services. Prevention and early diagnosis of illnesses and handicapping conditions can have huge payoffs in reducing the need for more costly treatment or remedial programs later and in helping children develop their full potential. Evidence from Head Start and other child care programs that provide health services show these to have long lasting and significant beneficial effects on children who would not have received them except for the program.

Evidence from EPSDT (the Early Periodic Screening Diagnostic and Treatment program) also documents the cost-effectiveness of these services to children. All state Medicaid programs must furnish EPSDT to Medicaid beneficiaries under age 21. Enacted by Congress in 1967, EPSDT was initially designed to finance wide-scale outreach efforts to identify, screen, and treat very poor children suffering from potentially handicapping conditions. Since then it has grown into a comprehensive program that pays for a broad range of preventive health services. But many of the children who most need EPSDT services — perhaps 70 percent of those eligible for them — do not receive them.

Health care agencies must provide the services and pay for them, but child care facilities are where the children are, and it makes sense to locate case management for individual children at the child care center level. Child care programs can help to ensure that children are screened and receive the preventive health care provided through EPSDT. They can also inform parents that their children may now be eligible for Medicaid. In 1984, Congress passed legislation mandating that all children under five living below state poverty levels (AFDC assistance levels) receive Medicaid regardless of their family situation. Over half the states had not allowed two-parent families, no matter

how poor they were, to receive Medicaid. Many parents do not know about this important change.

A healthy child is also a well-nourished child. The history of our school and child care feeding programs, which now offer at a minimum breakfasts, lunches, and a snack for preschool children, demonstrates that policy makers understand that a hungry child cannot learn. While the food stamp program offers families help in purchasing food, it is limited. Based on a thrifty food plan, food stamps provide forty-seven cents per person per meal. Child care programs that provide a well-balanced breakfast, lunch, snack, and if necessary dinner can both improve a child's nutritional status and also help to teach parents the benefits of sound eating patterns.

The importance of a nutritional component is highlighted by evidence of growing hunger. After a decade of progress in reducing hunger and malnutrition in America, these problems have reemerged in the 1980s. The Massachusetts Department of Public Health issued a major study in late 1983 which found that 10,000 to 17,000 poor children in Massachusetts suffered stunted growth, largely due to chronic malnutrition. Nearly one in five low-income children studied in the Massachusetts survey was either stunted, anemic, or abnormally underweight.

Social Services. Just as with health services, the provision of social services is often the cost-effective, preventive measure that children and their families need most but are least able to obtain themselves. For example, counseling when a child or family is experiencing a temporary crisis (a death in the family, a serious illness, or an emotional trauma) may make the difference between a family remaining intact or needing more serious, damaging, and costly remedies such as foster care or institutionalization. Assisting a family to apply for food stamps or helping one whose food stamps have been lost or stolen may directly improve a child's nutritional status. Identifying and treating children's developmental disabilities at an early age often makes the transition to school and success in school more manageable for children and their families, reducing the likelihood of grade retention or special education later on. New parents need to learn about available health care services and receive important help in learning how to care for their infants as well as support during stressful early months.

In addition to providing these services, child care programs can play a range of roles, including:

- Helping parents to develop self-help and advocacy organizations to bring about improvements in the community and improve the quality of family life;
- Building linkages between the child care program and professionals or paraprofessionals within a community who can support parents; and
- Providing support and counseling to parents and helping them to use the support they get from other professionals.

Education. More and more higher income families are seeking child care programs with an educational component (Chorvinsky, 1982). Because most of these programs are private and relatively expensive, the lack of support for child care for low-income families is contributing to the development of a two-tier system of care for our youngest children. Low-income children can reap significant benefits from a program with a strong educational component. Child care programs must provide activities that enhance every aspect of a child's development, including social, intellectual, emotional, and physical development. The educational program must be planned around clearly defined developmental goals and program objectives and give consideration to the concerns of parents, to cultural differences among children, and to children's special developmental needs.

Parent Involvement. Parents must be encouraged to see themselves as the primary teachers and advocates for their children. Child care programs can play a vital role in working with parents to help them reinforce a child's experiences in child care. They can also help families move toward economic security by actually hiring parents — 31 percent of Head Start staff are parents of current or former Head Start children — or by helping parents gain the confidence and skills they need to seek employment (Valentine, Ross, & Zigler, 1979).

Parents are ultimately responsible for their children's health and development. Meeting these responsibilities is difficult for any parent, but it is especially difficult for working or single parents. The task is made more difficult by unresponsive, exclusionary, or nonwelcoming programs. The child care center should provide outreach to parents to help them make important decisions affecting their youngsters and create an open atmosphere where they can freely interact, share information, ask questions, and get advice from caregivers.

Parents should also play a role in monitoring the quality of care that

is given at the center. Those parents who have the time and energy to devote to more active involvement should be given opportunities to participate at the policy-making level.

The Need for Subsidized Child Care

Supportive child care for low-income children has become less readily available as federal support for child care has diminished. The Title XX Social Service Block Grant, the largest source of direct federal support for child care and other services for children and families, was cut by 21 percent in 1981. As a result, thirty-four states cut their spending for child care between 1981 and 1983, sixteen of them by more than 21 percent (Blank, 1983). The reductions were carried out in several ways:

- Thirty-two states reduced the number of children served by making it harder for families to become eligible.
- Nineteen states increased fees for services, imposed minimum fees, or allowed co-payments for Title XX child care.
- Twenty-four states reduced funds for training child care workers.
- Thirty-three states lowered their child care standards for Title XX programs.
- Thirty-two states cut back the size of the staff that monitors and licenses programs.

The Dependent Care Tax Credit, which is our largest child care program, costing only \$2 billion, is available to all families regardless of income. It can provide important help to lower-middle-income families, but families with limited disposable income are not the primary beneficiaries of this approach to subsidy. A young mother who is enrolled in school or in a training program and who has little or no income cannot use a tax credit to help her meet her child care needs.

The gap between the supply of child care available to low-income families and the need for it is significant (Blank, 1984):

- In Georgia, child care programs funded by Title XX serve approximately 8,200 children and have a waiting list of 5,000.

More than half the counties in the state have no Title XX child care funds.

- In Los Angeles County, California, there is no licensed, regulated child care available for approximately 135,000 children under age five who need child care. Estimates show that more than 300,000 children age five to fourteen with employed parents need after-school care.
- A report prepared by the Maine Child Care Task Force reveals that 500 children age five or younger spent time during a typical week caring for themselves. Another 2,500 children under age three and 1,000 children age three to five were sometimes left at home alone with only a neighbor or friend occasionally looking in on them. Almost 25,000 Maine children age six to twelve spent an average of more than four hours a week caring for themselves.
- New Mexico, which serves approximately 3,700 children, estimates that more than 50,000 children need child care.
- Cuyahoga County, Ohio, currently spends \$9.1 million a year for child care assistance and estimates that an additional \$8.2 million is needed to serve all families who need assistance with child care.
- Recent data from Massachusetts resource and referral programs suggest that only about a third of the state's families needing child care are able to find the kind of care they want at a price they can afford.
- The Child Care Impact Committee in Oakland, California, found that almost one-third of the parents they surveyed had to take whatever child care they could find. Only a third thought that they had an adequate choice.

The changes in eligibility for child care assistance are making it harder for mothers to gain the training necessary to obtain jobs and move their families out of poverty. They are also resulting in policies that punish poor families for small steps they take up the economic ladder. In states that do not have a sliding scale for eligibility, income guidelines penalize parents who receive small wage increases. A small economic gain can force parents to move their children from familiar caregivers to less costly and less supportive arrangements. Mothers sometimes refuse promotions because even a minimal pay increase can lead to the loss of a \$2,500 child care subsidy.

If we are to move ahead in helping low-income and single parents

become independent and move out of poverty, we must be honest about the resources necessary to undergird a supportive child care system. New federal and state initiatives are needed both to provide additional help to families in meeting their child care needs and to improve the quality of child care. Such support is the key to insuring that young children whose parents are struggling to be self-sufficient receive the care they need during their important developmental years and in their turn become productive adults.

DISCUSSION

Sandra Scarr: It's really depressing to think about the needs. What is even more depressing to me is that even figures that you give for the cost of child care seem to assume that a working mother has only one child.

Ellen Galinsky: Studies have found that the costs of child care are between 10 percent and 30 to 40 percent of a family's income. Obviously the more children a family has and the lower the family income, the higher the percent of that income that child care is going to cost.

Susan Aronson: What kinds of things can we do to try to get a federal consciousness-raising that will allow for improved funding?

Helen Blank: The arguments for child care are strong. We must keep making the case about child care's relationship to self-sufficiency for adults as well as to children's futures. It's hard to keep asking when people say "not this year." Many groups have stopped trying. We have to continue to think that it is worth the time to work for an expanded federal role in child care. It's not easy, because we will not necessarily come up with a large victory that will buoy us up, but with persistence we will take small steps.

Many new constituencies representing the different services in child care — resource and referral programs, school-age programs, family day care providers — are emerging and putting intense effort into garnering support for a particular component of the child care system. It has been helpful to channel the energies toward particular programs to convince legislators of their importance.

There is also room for significant action at the state level. We are publishing a state child care fact book which has a page for every state, so that policy makers can compare what their state has done with

other states' child care agendas.

Dana Friedman: It strikes me that as a matter of policy we have a choice between having diversity in the child care system, as at present, and getting funding. The argument for public school involvement in child care is that it will get more money, that state legislatures don't want to fund child care in its disparate forms. They may feel more comfortable funding the public school system, which with all its problems is still a visible institution. Is it a choice between preserving that kind of diversity versus assuring ourselves the kind of money that we think we need to fund the system adequately?

Helen Blank: I don't think it has to be a choice. We have a long way to go before the schools will provide child care even for one age group. They are only considering four-year-olds. The public schools will never be interested in serving infants and toddlers. I think you can expand their role and still preserve choice. The Massachusetts bill allowing education money to flow to different entities for different kinds of services is an example.

Elinor Guggenheimer: I do think there are some hopeful signs, despite the gloomy picture. The picture has become gloomier in one sense, because more mothers are working and there's more need for child care. But when I started working in child care, in the '30s through the '40s and '50s, I wouldn't even have dreamed of going to a corporation like Johnson & Johnson and saying, "Could you become interested enough to bring a group together to discuss child care?" I don't remember any corporate involvement at all at that point. There is movement, there is a great deal more interest.

I am also interested in how we can use the school system. The facilities are there in every community that would take a long time to replicate in the numbers we're going to require. Even if it's a long-term push, we need to look at it.

Judith Palfrey: The public schools have been our agent of change. If you look back at the integration of various religious groups in the 1860s, that's where it began. The integration of immigrants into the society in the 1890s happened in the public schools, and then racial integration, and most recently, the integration of handicapped children.

Ellen Galinsky: Whose needs are being thought of when we make policy? As we all know, it's not the children's needs but the adults' needs. We need to move toward a policy that considers not only the adults' needs for employment and training but also the children's needs. Bank Street is doing a study now with Ann Mitchell and

Michelle Seligson from Wellesley on four-year-olds in the public schools. They are going to look at the variety of different policy objectives in different states that have managed to do what Helen suggests, which is to integrate services, to channel money in different ways, and to present an approach that is diversified rather than just the one magic pill that we seem to keep wanting in this country.

Sandra Scarr: I am very optimistic about the things that Dana Friedman and Elinor Guggenheimer are finding and initiating with respect to working families and corporations, and the general community awareness of child care issues. I'm very afraid, though, that we're going to have an even greater discrepancy between the middle-class working families and what's happening with the poor. Institutions see it in their own interest to provide these services. Who's going to represent that interest for the poor? There are good reasons why we should provide child care for the poor, but I don't think we've made that case to the public.

CHILD CARE AND THE HANDICAPPED CHILD

Rebecca R. Fewell, Ph.D.

When a family has a handicapped child, the lives of all family members are affected. The responsibility for providing care for the handicapped child for extended time periods makes these families different from other families. Most notably, they have far fewer options for child care, and their priorities for their child and for group care are different from those of other families.

Group care service providers are also affected when they accept children with special needs. They must have a higher ratio of staff to children, and the staff must have special training. They must make special arrangements in the physical space. Special or adapted equipment and learning materials will be needed, and emergency medical care must be available.

This paper describes the adjustments that family members and child care staff must make to serve the special child. It discusses parents' expectations for group care, desirable group care environments, benefits of group care, and criteria for selecting group care services for children with special needs. Finally, it suggests a policy for group care that would recognize the needs and limits of families with young handicapped children.

The Child with Special Needs

Handicapped children are a heterogeneous group. Even children who share the same diagnosis may have vastly different needs. A child's condition and subsequent needs also change over time. These factors make it important to refrain from making assumptions about a child's behaviors or needs until the environmental supports and conditions that will help the child live as full a life as possible have been identified.

When children have diagnosed conditions such as Down's syndrome or cerebral palsy, they can be expected to have certain atypical physical, mental, or emotional characteristics identified with those conditions. We can often anticipate certain general needs, such as the need for physical therapy for the child with cerebral palsy and for early educational intervention for the child with Down's syndrome. Regardless of the nature of their impairment, handicapped children need care providers with special training, and their families need help in learning how to use their own strengths and resources to nurture the development of their children, whose styles of learning and developmental patterns may be quite different from those of other children.

The Family of the Child with Special Needs

Current theorists writing on families with handicapped children emphasize the need to use a family systems theory to describe the multiple transactions that occur between persons and environments. There are innumerable events in the family's life that interact with the presence of the handicapped child to determine effects on the child and the family. Acceptance of and adjustment to the handicapped child are often described within a stage model. Drotar et al. (1975) hypothesized a five-stage sequence of parent reactions:

1. *Shock*. Parents report overwhelming reactions of shock at the news that their child has an anomaly.
2. *Denial*. Parents try to escape the information or to lessen the blow somehow. When the child's problem is not visibly obvious, parents' denial reactions may be stronger or experienced for a longer period of time.
3. *Sadness, Anger, and Anxiety*. Parents face the reality that the child's problem is not going to go away, and they grieve. Feelings of anger, often directed at the child, the spouse, or the doctor, are also common.
4. *Adaptation*. Parents gradually come to terms with their child's disability and begin to seek and effectively use help from service providers. The process appears to be shaped by the strengths of the parents and their own coping skills.
5. *Reorganization*. The family goes through a complex period of adjustments, which may include changes in the family structure, style of living, and work plans.

A number of researchers have reported similar reaction stages (Emde & Brown, 1978; Solnit & Stark, 1961), but others have questioned the validity or value of a stage theory (Searle, 1978; Blacher, 1984; Wikler, 1981).

A critical factor in determining how parents adapt to the stress of having a handicapped child is the emotional and material support available to them (Unger & Powell, 1980). Particularly important are the social networks that support the family: relatives, friends, neighbors, and acquaintances. The stress of raising a child with specific needs may be mediated by the availability of social supports (Fewell, 1984; Vadasy & Fewell, 1986). Parents who decide to seek group care services for their child with special needs turn to family, friends, and social supports for help in selecting these services, talking over their feelings, their worries, and their anxieties and seeking advice and recommendations.

The birth of a child with a handicap causes many families to reassess their goals and values. One of the plans that many parents alter is the plan to return to work after the birth of their child. Some parents feel their child needs their care and attention during the child's early, vulnerable months, a time period that is likely to be considerably longer than anticipated, and may delay returning to work, change careers, or quit working entirely.

Dimensions of the Problem: Needs and Services

Statistics on the number of handicapped children who have mothers in the labor force are not available. Applying prevalence rates for handicapped groups to the population of children under age six, however, we can estimate the number of handicapped children under age six at about 2,300,000. If the percentage of parents of handicapped children in the labor force is approximately the same as that of other parents — 52.2 percent in 1980, projected to rise to 59.4 percent in 1990 (Select Committee on Children, Youth, and Families, 1984a) — we can project estimates of 1,106,604 handicapped children with mothers in the work force in 1980 and 1,475,303 in 1990, with a mid-decade estimate of 1,290,953. If this many families need group care for their young handicapped child, we have a most serious and largely unrecognized problem. These families need support policies that relieve family stress and help them stay together and active in caring for their handicapped children.

The availability of child care services for handicapped preschool-age children has been examined in a few discrete regions of the country. Berk and Berk (1982) surveyed seventy day care centers in the metropolitan Washington, D.C., area. Of those that responded, 58 percent — generally the larger centers, with more financial and staff resources — indicated they were willing to accept handicapped children into their programs. Many, however, required the children to be toilet-trained, and ten would not accept nonambulatory children. In total, only thirteen of the seventy centers surveyed were willing to accept handicapped children regardless of whether they were ambulatory or toilet-trained. Two barriers to acceptance of the handicapped children were identified: lack of trained staff to meet their special needs, and the added expense of structural changes and special care.

Group Care Arrangements for Handicapped Children

Parents of handicapped children use many different kinds of programs for their young children. Often they must use combinations of programs because no single program meets the child's educational and therapy needs as well as the parents' day care needs. The four group care arrangements to be described appear to serve the majority of the young handicapped children.

Early Education Programs. The number of early intervention programs has increased dramatically during the last ten years. This increase is related to: (1) the desire on the part of parents and professionals to begin addressing a child's needs as early as possible; (2) the availability of federal funds through the Handicapped Children's Early Education Assistance Act (HCEEP, P.L. 90-538) of 1968 and subsequent federal and state laws; and (3) research findings supporting the effectiveness of early education programs for at-risk (Schweinhart & Weikart, 1980, 1981; Lazar & Darlington, 1979) and handicapped children (Karnes et al., 1981; Moore, Fredericks, & Baldwin, 1981; Hayden, Morris, & Bailey, 1977). The cost of educating handicapped children is significantly reduced if education is begun early and children can acquire skills that enable them to be served in less restrictive environments (Antley & Fewell, 1981; Garland et al., 1981).

In most HCEEP model programs, group care is subordinate to the educational services provided to the child. The programs vary widely in the target populations they serve, the service delivery model they use, the hours they operate, the goals they espouse, and the ways in which they evaluate their effectiveness. They may serve children with a specific impairment or all handicapped children within a single region regardless of the nature of the impairments. They also differ in their theoretical perspectives, goals, intervention practices, staffing patterns, and outcome measures.

A few early intervention programs provide child care services for working parents. Of the 83 demonstration sites in the HCEEP network in 1984-85, four programs described some form of child care, but all four programs limit their offerings. HCEEP group care programs for handicapped children thus focus almost entirely on the child's education program. The programs are primarily part-time. When child care is provided, it is not the major focus of the program and would not meet the needs of the parent with full-time employment.

Segregated Group Care: Special Populations. Much of the group care available for handicapped children has been arranged to serve a specific population. For example, Project CARE (Carolina Approach to Responsive Education) was a three-year research program designed to investigate the effectiveness of two experimental models of developmental child care with children at risk for developmental delay (Ramey et al., 1985). After three years of intervention, children in the Developmental Daycare Plus Family Education group had Stanford Binet scores significantly higher than children in the Family Education Alone Model and a control group that received no services. This

important study demonstrates that a developmental intervention and family education program can be successfully implemented in conjunction with full-time child care.

Integrated Child Care: Handicapped and Nonhandicapped Children Learning Together. The Northwest Center Infant and Toddler Program in Seattle, Washington, is an example of an integrated full-day group care program. This center serves 48 children, with equal numbers of handicapped and nonhandicapped children. The program features developmentally integrated small groups, individual development plans for all children, and opportunities for normal and atypical group development as well as extensive parental involvement (Gil, 1982). Although no data have been published on the effectiveness of this service delivery model, the program has been funded as an outreach model by the HCEEP program.

Family Day Care. Family day care probably serves more handicapped children than any other arrangement. Parents often find these arrangements themselves through their social support networks. Contributing to the popularity of this model are the flexibility of hours, the cost and convenience of these arrangements, and the home-like atmosphere parents often look for when they select a site for their young child.

Differences in Environments for Handicapped and Nonhandicapped Young Children

Bailey, Clifford, and Harms (1982) compared preschool environments for handicapped and nonhandicapped children. In a number of significant areas, classrooms differed in favor of those for nonhandicapped children. The differences between the environments were greatest on comparisons of room arrangement for interest centers, relaxation, and comfort; creative activities; and social development. The most noticeable difference was the minimal emphasis on creative activities for the handicapped children. Since it is just those kinds of learning arrangements that are conducive to generalized learning in least restrictive environments, their inclusion may be very important for children with special needs.

Observations on the different social and educational aspects of mealtimes for handicapped and nonhandicapped preschoolers were

provided in another study by the same investigative group (Bailey, Harms, & Clifford, 1983). The researchers felt that mealtime for handicapped children needed to be even more of a learning experience than for the nonhandicapped children. Yet the observers noted that in none of the programs for handicapped children were children encouraged to serve themselves, to determine serving sizes, to choose the foods they preferred, or to pour their own beverages. The nonhandicapped children were more likely to be encouraged to perform these tasks and to be permitted to leave the table if they finished eating before the others, suggesting that nonhandicapped children have more opportunities to exercise independence and personal decision-making in their school setting.

These findings of differences in environments and experiences should be of interest to at least four groups: (1) parents, who need this information to help them identify the most suitable program for their child and to provide supplementary experiences to make up for those lacking in their child's program; (2) professional child care providers, including educators, who need to be aware of how experiences for handicapped and nonhandicapped children differ; (3) professional personnel trainers, who need to prepare future staff to minimize these classroom differences; and (4) funding and licensing agency staff, who should be aware that programs for handicapped children often differ widely and therefore cannot be compared without accounting for these differences.

Social and Educational Contributions of Integrated Group Care Centers

A now-famous study (Goldstein, Moss, & Jordan, 1965) found that school-aged handicapped children performed as well in classes with nonhandicapped children as they did when educated in separate classes and facilities. Leading special educators viewed this finding as a strong indication that segregated facilities were discriminating and failed to provide equal opportunities for learning. These conclusions were taken to apply to children of all ages, with all types and degrees of impairments, and led to the concept of the education of persons in the least restrictive environment, a concept incorporated into Public Law 94-142. There are no data to support the original findings with groups of younger children.

Other studies have specifically examined mainstreaming handi-

capped children into settings with nonhandicapped children (see Guralnick, 1978, for review). Social interaction studies have been based on the assumption that more contacts between handicapped and nonhandicapped children will result in more positive outcomes for the handicapped children in their social, emotional, and cognitive development. While a number of studies (Cooke, Apolloni, & Cooke, 1977; Guralnick, 1978) have identified ways nonhandicapped children can positively influence handicapped peers, it is quite clear from other studies (Devoney, Guralnick, & Rubin, 1974; Feitelson, Weintraub, & Michaeli, 1972) that children's mere exposure to appropriate models is insufficient to obtain desired results.

Smith and Greenberg (1981) found in a small study that mainstreamed children demonstrated fewer significant gains than non-mainstreamed children over the course of the academic year. It was also noted that teachers felt the integrated children's perception of being different was heightened by their mainstreaming experience, suggesting that mainstreaming could have a negative effect on a child's emerging self-concept. In general, the study supports others who have found that the mere placement of handicapped children with non-handicapped children is not sufficient to bring about their meaningful integration.

Appropriate Group Care Environments for Young Handicapped Children

Optimal group care arrangements for young handicapped children promote learning, social interaction, and independence through physical arrangements and learning opportunities within the environment. A handicapped child needs a physically responsive environment in which to learn that his or her behavior can affect the environment. Adaptive arrangements include comfortable, accessible space and physical and social arrangements that encourage successful encounters. These arrangements might require adaptive equipment, lighting, and sound absorption and increased personal space as well as challenging spatial arrangements. Hutt and Viazey (1966) demonstrated that as group size increased within a classroom, both nonhandicapped and handicapped children exhibited increased aggressiveness. Harms and Cross (1977), Olds (1979), and Bailey and Wolery (1984) provide excellent suggestions for spatial arrangements. Such arrangements should facilitate the child's perception of self-control and indepen-

dence, necessary for handicapped children to function effectively in less restrictive environments. The activity areas should be flexible enough to meet the needs of the handicapped children and should include areas for blocks, housekeeping and dramatic play, academic concepts, music, arts and crafts, sand, water, and physical exploration, sensory learning, and indoor and outdoor motor activity.

To facilitate learning in handicapped children, curricula must be consistent with the staff's theoretical perspective and responsive to each child's particular special needs. Fewell and Sandall (1983) compared a number of currently available preschool curricula and suggested guidelines for adapting curricula for special populations. Other curriculum reviews and suggestions can be found in Anderson (1982) and Mori (1983).

The inclusion of parents in the early learning experiences of handicapped children has been viewed by many as a key to successful early experiences. Special arrangements for involvement by working parents may be needed.

Staff who are responsive and responsible child care agents are vital to a successful group care arrangement. Their relationships with one another and their continued growth through in-service training and other opportunities for increasing their skills are crucial.

Selection of Group Care for the Child with Special Needs

Different families have different priorities, but all will have the following concerns in selecting the best situation for their child:

1. The qualifications of the director and the staff and their flexibility in adapting to the handicapped child;
2. A staff-child ratio appropriate to the nature of the child's impairment;
3. Access to therapy services;
4. A physical environment adapted to the child's specific impairment;
5. Staff availability to parents for brief exchanges of information at the beginning and end of the day;
6. Willingness to work with the child's other service agencies, such as medical, educational, and social services;

7. The staff's response to the child as an important, worthy person;
8. The child's response to the staff and the center, often communicated indirectly;
9. Convenience of location;
10. Availability of an education program;
11. Cost of the program;
12. Opportunities for additional family services.

Conclusions and Recommendations

The parents of a handicapped child must begin early to adjust their lives to meet the needs of their child. The adjustments affect every aspect of their lives: their emotional and social lives, their living arrangements, their work arrangements, and even their goals and values. In light of the increasing numbers of mothers of preschool children joining the work force, it seems critical that policy makers consider the need for research and services to support these families during the child's early years. Future policy directions might include: (1) special funds to develop model, full-day, educational group care programs for handicapped children of working parents; (2) small grants or cash subsidies for families to acquire the full-time educational and group care services they need for their handicapped children, carefully monitored so that funding agencies could identify programs parents value most and parents' strategies for solving their own problems when given adequate fiscal support; (3) funds for the training of early childhood special educators to serve in full-day child care centers and to develop programs that are appropriate for full-day care; (4) research funds to determine the effectiveness of various physical and staff arrangements; and (5) research funds to examine the cost of effective full-day care arrangements and to determine the kinds of arrangements that are best for children and families of different socio-economic levels and in different locations.

Work-site sponsored group care is not a practical option for handicapped children. Government support and the involvement of health care and educational agencies will probably characterize most successful group care programs for children with special needs, given the children's specialized care needs, their distribution across geo-

graphic areas, and their parents' distribution across work sites. Ongoing financial options for these programs might include long-range financial support from a corporate or private sponsor, corporate subsidies for an employee's child, corporate purchase of slots in the program, and the formation of a consortium of corporations, small businesses, hospitals, and other organizations to sponsor jointly these special and high-cost group care centers. All these alternatives will need to be considered by individual communities to find the formula that is most likely to result in a quality, affordable group care program that offers parents of handicapped children a full range of options for their employment and personal development.

DISCUSSION

Susan Aronson: In Pennsylvania, through P.L. 94-142, services have been extended down to the preschool and now down to infancy; they include identification, diagnosis, and child care placement. They are funded through mental health and mental retardation funds, and there is a sliding fee scale. This progress has taken place in the face of cutbacks in availability of child care generally for children with disabilities, in an area where the cost per individual child is great. Frankly, I think we need to recognize a problem when we talk about limited child care resources and the cost of child care for children with significant disabilities. Governments with limited resources have to make decisions about where to allocate that money and how many people can be cared for with how many dollars.

Helen Blank: Don't make policy makers choose among groups of children. I don't mean to pit the elderly against them, but for the elderly it would be better to take a quarter of a percent off the cost of living.

Judith Palfrey: In fact, the elderly are the allies of handicapped children. The change that you make in an airport for the elderly in wheel chairs is the same change that you make for the child with cerebral palsy. These two groups should march behind a similar banner.

We have done some studies in five cities around the country of children in P.L. 94-142. We found that the enrollment in early education programs or preschool programs for children who are identified as handicapped has increased substantially in the past

decade, but there is a persistent inequity in care between white and black that looks just like the infant mortality curve.

Michael Yogman: With regard to mainstreaming, in Massachusetts there is enormous growth in completely separate programs for handicapped infants. A whole separate system of early intervention programs through the Department of Public Health is serving some of the needs of the children and families, but with a separate professional constituency, a separate lobby, and a separate package of services administered through a separate agency, the state government. There is no linkage with child care. In fact, one of the problems for our program is how to provide extra services for the premature infants who are also going to need early intervention programs; they are worlds apart.

Sandra Scarr: The handicapped have been a particularly effective lobby in the last ten years, not only for handicapped children but for adults as well. Maybe we have something to learn from this for the rest of the children, the other 95 percent who are not seriously impaired.

Elinor Guggenheimer: I'm not sure we can learn too much from what is done for handicapped children. They can run a dinner and clear \$4-500,000 for a defined group of children, whereas if we go in for the tens of millions of children, it's almost an impossible thing to sell because it's such a large, amorphous group.

Judith Palfrey: But in fact the kind of services you can get for the cerebral palsy child or the muscular dystrophy child are wheel chairs and very concrete things. Nobody wants to give respite care and child care services. So even for those groups where the need is obvious, these kinds of services are not available.

Betty Caldwell: Rebecca mentioned something that I see as one of the most important things, and that is the need for child care providers to have consultative services. Over and over I hear people say they are not trained to help children, they are afraid that children will regress in their centers because they don't know enough about how to deal with a deaf child, with the physically handicapped, and so on. It is a crying need.

Juanita Fleming: We are going to see new groups of special needs children emerging. I recently heard the mother of a ventilator-dependent child making plans to find child care. Children are leaving the hospitals and going home on high-tech equipment. Some of them are getting their medication intravenously, but otherwise they could

probably be in child care. They will require some very capable people in child care settings.

Ellen Galinsky: One point I want to make, however, is that parents don't want people to stereotype their children. They want people to see them as whole children and not to see them only in terms of their problem.

PROGRAMS FOR INCARCERATED MOTHERS AND THEIR CHILDREN

Margaret D. Wishart

It has been conservatively estimated that one-quarter of a million children are separated from their mothers each year because of the parents' incarceration. Yet, until quite recently, there has been little or no help for imprisoned mothers and their children. These children are forgotten victims, subject to stigmatization, economic deprivation, and emotional turmoil. They are five times as likely as their peers to be labeled as delinquents.

A growing number of programs throughout the country are attempting to address the needs of both inmate mothers and their children. In this paper, three examples of program models — residential/institutional, residential/community, and children's center — are described, and ways in which the community can support these separated families are discussed.

The Mothers

While parents obviously come in both sexes, there are important reasons why the majority of inmate parent-children programs are

geared to women. Although the latest figures from the Bureau of Justice Statistics (1985) showed that women made up only about 4.5 percent of the national prison population in 1984 (20,853 out of 463,866), it is estimated that about 70 percent of any institution's female inmates are mothers of dependent children and that 80 percent of these mothers have legal custody of their children and have been caring for them as single parents prior to incarceration. Therefore, unless these children can be taken in by family or friends they will, of necessity, become the responsibility of the state. By contrast, most children of inmate fathers remain in the care of their mothers or other female relatives.

According to the Association of Programs on Female Offenders (Boudouris, 1985), about one-quarter of the women in prison are pregnant or have young children. (At Rikers Island, for example, approximately 8 percent of the 8,500-9,500 female inmates admitted each year are pregnant.) Eighty percent of inmate mothers are unemployed and on welfare prior to incarceration. Half of them have had at least one pregnancy by the age of sixteen, and one-third have been abused by their own parents and/or by spouses or lovers. Most of the mothers resume the care of their children after discharge from the institution, although about 25 percent of them will have their right to the legal custody of the children challenged. A study (Novick et al., 1977) of 1,300 males and 120 females entering the New York City Department of Correction during a two-week period found that 75 percent of all the population were thirty years old or less; 57 percent were black, 24 percent were Hispanic, and 19 percent were white or other. Less than 50 percent had a high school diploma; 16 percent had an elementary or no formal education at all. Seventy-two percent of the women were found to have at least one serious medical problem, the most common being drug addiction (23 percent), psychiatric illness (10 percent), hypertension (10 percent), and respiratory disorders (6.7 percent). Sixty-three percent of the women had had a prior hospitalization, and 9 percent of them were currently taking medication. Seventeen percent showed signs of recent trauma.

Notable among these findings, which have been supported by other studies of large urban jails, are the large percentages of women belonging to minority groups. Not surprisingly, since many of these inmates are ultimately sentenced to prison, Wyrick and Owens (1977) found similarly disproportionate numbers of minority women in *all* federal and state prisons of whatever size. Fifty percent of female federal prisoners and 48.8 percent of state prisoners were found to be

black, in contrast to the 11 percent of all American women who are black.

On the basis of these studies it can be predicted that upwards of 75 percent of the inmate mothers in the United States will be from minority groups and will share with nonminority prisoners a history of poverty, undereducation, underemployment, and the disproportionately high incidences of disease that are common to the poor everywhere. In addition, as Shaw (1981) reported on a series of interviews conducted with women at Rikers Island over a three-month period, the mothers will be racked with worry about their lack of control over the financial, physical, and emotional well-being of their dependent children. Losing their children is a real fear. Most jails have social workers who do their best to prevent this from happening, if possible, but they have huge case loads, and most of their work is crisis intervention.

The Children

The Association of Programs on Female Offenders estimates that approximately one-quarter of a million children are separated from their mothers by reason of incarceration. The length of separation can range from a few days to years. From the very moment of arrest or sentencing, these children are likely to be plunged into an emotional turmoil of bewilderment, fear, confusion, and anger. Carroll (1980) reported on children coming home to an empty house and being alone for hours because their mothers were loath to inform the arresting officers of the children's existence for fear that they would immediately be placed in foster care. The case of a child in one of the programs I will describe below is typical. She told of being at court with her grandmother while the mother was on trial, seeing the adults sobbing one day, then not having any contact with her mother for a long time and feeling tremendous anger and guilt at being deserted.

There is a widespread feeling in our society that children and prisons do not belong together. When we did a little survey of 200 inmates at Rikers before we developed the nursery program, only 3 percent of them said they were interested in having a nursery. Most of the rest felt they wouldn't want to have their children even come near the prison, even if there were a nursery. I found that at Bedford, too, among some of the parents. It's not only the families of incarcerated women but sometimes the prisoners themselves who feel this way.

Many families, with the best of intentions, try to keep the whereabouts of an incarcerated parent from the children. Sometimes, with less good intentions, the families want to punish the mother by depriving her of visits with her children. The children are most likely told that the mother is very sick in a hospital and cannot be visited. At best, this situation is frightening and mystifying; it can quickly become devastating if the children find out from an outsider that their mother is in prison.

But even if the children's guardians tell them the truth and plan to bring them regularly to the prison for visits with their mothers, it is not easy. Because the female prison population is small, in virtually all states there is one prison for women serving long sentences. The prison may therefore be hundreds of miles from the inmate's home, and even if it isn't, it is likely to be in a remote, rural area, with difficult and expensive access. Consequently, a visit by the inmate's children may be a rare occurrence and not lightly undertaken by a frail grandmother if there are several children involved. School-age children, already subject to stigmatization by their peers, may be reluctant to visit their mothers in the prison setting and, if they do, the visit may be awkward and constrained for both parties. I myself have many times seen bewildered children clinging to their caretakers, obviously wary of this stranger whom they are suddenly expected to hug and kiss and play with. The mothers also are frequently at a loss as to how to behave, especially if, as is often the case, they are beset with guilt over the suffering their imprisonment has brought to their children.

According to the Association of Programs on Female Offenders, children of inmate parents are five times more likely than other children to be labeled as delinquents. An article in the *Wall Street Journal* (Freedman, 1985) reported on a series of interviews with two dozen children of incarcerated inmates in six states. The children described the cruel taunting by other children and getting into fights because of it. One girl was thrown out of school because she had beaten up a classmate who was telling people that the girl's mother was in jail. Many of the children spoke about problems with drugs and alcohol, delinquency, and truancy. Even when the children are able to remain with supportive family members, financial and other pressures tend to militate against the stability of the family group. Those of us who are familiar with women's prisons can vouch for the truth of the observation that the children of incarcerated women do their own time along with their mothers.

The Programs

The programs that currently exist for inmate parents and their children are relatively few, serving only about 10,000 of the 250,000 children who are separated from their incarcerated mothers each year. Nevertheless they encompass three distinct models: residential in the institution, residential in the community, and children's center within the prison or jail. Whatever the model, the goal is the same — to promote bonding and/or to maintain and strengthen family ties between inmate parents and their children. All the programs offer a specially designed area where parents can be with and play with their children in a supportive environment, and all offer special services to the parents, which range from parenting training to social service and legal support. Most of the programs are run by professionals from the community and in many cases depend heavily on community volunteers. With few exceptions, funding for the programs is provided by private foundations and community agencies rather than by the department of corrections. An example of each model is discussed below.

Rikers Island Nursery Program. Statute 611 of the New York State Correctional Law, which was enacted in the 1930s, allowed a woman who gave birth while in custody, or who was nursing a child under one year of age when taken into custody, to keep the child with her in the prison or jail for twelve months. At Bedford Hills Correctional Facility, which is the only prison for women in the New York State Department of Corrections, women have in fact been able to keep their babies with them since that time, and the nursery program, which houses about eighteen infants at present, is currently the only residential prison nursery (for sentenced inmates) in the United States. Since Rikers Island primarily houses detainees awaiting adjudication of their cases, the nursery there is more correctly described as a jail nursery.

In 1982, Statute 611 was tested in New York City, when an inmate brought suit against the City Department of Correction. Rather than enter into a protracted legal action, the department (wisely, I think) decided to go ahead and develop a nursery program before possibly being ordered to do so. Although funding was supplied by the department, the decision was made to contract for services with Montefiore Medical Center, a large teaching hospital in New York City which since 1973 has provided medical services at Rikers Island, the major detention center of the system. At the Correctional Institution for Women, where the nursery is located, our medical staff had

offered weekly pre- and postnatal parenting classes to pregnant and other interested women for many years. Therefore, we welcomed the opportunity to expand this service within a residential setting under the guidance of a specialist in early childhood development and a midwife/nurse practitioner.

The nursery, or Family Development Center, as we prefer to call it, opened in early 1985. It is a large, cheerful apartment-like setting and houses up to five babies. The mothers' daily routine includes regularly scheduled classes, individual and group counseling, and recreational activities, as well as the actual care of the babies. If a mother is a sentenced person, by law she has to work, so she has the option of doing some of the work within the nursery — the cleaning, for example. If she chooses to work somewhere in the institution, we train other inmates to be caregivers, and those women in turn are paid to come in and care for the babies part of the time during the day. But the mother must assume the major responsibility for the physical care of the child.

The goal is to equip the mothers with the knowledge and skills to become responsible and caring parents. The baby's father and other family members are encouraged to visit, and when appropriate, they are included in the discharge planning that begins as soon as the mother is admitted to the nursery. Working closely with the Department of Correction Social Services Unit, the nursery staff ensures that all mothers and babies have a suitable place to live after discharge and that they will be able to obtain needed financial and other support.

The criteria for admission to the nursery have been developed between the Department of Correction and us. The Department of Correction has fairly strict standards. If a woman has a history of violent fighting with other inmates in the institution, she's likely to be excluded. Anybody who is detained on a child-abuse charge is excluded. And women may be temporarily excluded if they commit infractions while they're resident in the nursery. That happened recently to two of our mothers; they began to fight with each other in the nursery. They were both put in punitive segregation, and our staff took care of the babies. We made the decision not to put the babies out to the families — and in both cases there were families willing to take them — but to take care of the babies ourselves.

Being a drug addict does not automatically exclude a person from the nursery. At least two or three of our mothers were addicts, and the babies had to be withdrawn in the hospital after birth. The addicted

babies have remained in the hospital for a number of weeks before they could come back.

Since I'm responsible for the administration of the substance abuse services, I'm interested in why the percentage of women needing detoxification from drugs is higher than it is for the men. I think it's because judges by and large are sexists and tend to send males to jail much earlier in their drug offense careers than women. They are much more paternalistic toward women and give them more chances. So perhaps by the time the women come to jail, they're already well into drug offenses. This may be their fourth or fifth offense. By that time, they may be a little older and really serious hard-core addicts. Not surprisingly, there are many health problems associated with drug addiction, a lot of cellulitis, for example. Generally speaking the women are not a particularly healthy group: we see much gonorrhea, syphilis, a lot of asthma, epilepsy, a lot of problems common to poor urban populations, because most of our inmates there and in other large urban jails like those in Chicago or on the West Coast come from very deprived backgrounds.

Branden House (Residential community). Branden House in San Jose, California, is a community-based facility for women which runs two programs for inmate mothers and their children. The first is the Pregnant Mothers Program, which is operated under a contractual arrangement with the Federal Bureau of Prisons. A pregnant woman from any federal prison may be sent to Branden House for the last two months of her pregnancy. Her baby is delivered in a community hospital, and she remains at the facility for another two months. If her parole date comes shortly after her four months' stay, she may be allowed to remain and be released from Branden House. If she returns to prison, the program will attempt to find her a community support program in the area to which she will ultimately be paroled. In either case, Branden House works with the mother to develop an appropriate plan for the placement of her child and to address her other social service needs.

Branden House also operates a Mother-Infant Program for state prisoners under a contract with the California Board of Corrections. California State Law AB 512 allows female prisoners with children up to six years of age to live with them in a community setting six years before their parole date. Most of the women admitted to Branden House under this law are within one and a half to two years of parole.

Branden House offers a parenting program to women in both groups while they are in residence, as well as medical services and

recreational activities. There is a professional staff of eight and limited use of volunteers. The program appears to enjoy broad community acceptance as well as tangible support from various churches and other organizations in the form of clothes and other needed articles.

Prison MATCH (Children's center). The Prison MATCH (Mothers and Their Children) program at Pleasanton Federal Correctional Institution in Pleasanton, California, is the pioneer among children's center programs and the model for several others that have sprung up throughout the country in the past few years. Established in 1978, this program has four components:

1. *The Children's Center*. This specially equipped area inside the prison is a place where inmates and their children can spend time together at the weekends to strengthen family ties through play and learning activities. The staff is made up of volunteer child development professionals and other inmates. The Center is open to any child visitor to the prison up to the age of sixteen.
2. *Supportive Services*. With the objective of ensuring the child's welfare, the program offers social services which include assistance with foster care and custody problems, crisis intervention, and referrals to other agencies.
3. *Parenting Training and Early Childhood Education*. This part of the program is open to inmate parents and nonparents alike, who can volunteer to work in the Center, participate in formal workshops, and help take care of their own and other children.
4. *"Reading is Fundamental" (RIF)*. This is a program jointly supported by government and community funds which provides books for inmates' children to select and take home with them.

Prison MATCH attributes the success of its program to two important principles: (1) the inmates themselves were full participants in program development, and (2) the program has always been staffed and administered by professionals from the community, who bring the appropriate expertise to the program and are free to act as advocates for the inmate parents and their children not only in the prison but in the community.

Conclusions and Recommendations

Improving the lot of prisoners is uphill work at best. As the prison population increases and as beleaguered legislatures wrestle with inadequate budgets, it is unlikely that special programs like those for inmate parents and their children will be a high priority for correctional authorities, unless mandated by the courts. It should be noted also that some parent program administrators feel it is preferable not to institutionalize these programs but to intensify efforts to base them fully and firmly in the community. Most of the programs that currently exist depend heavily on community support, both for funding and for personnel. Their success underscores the validity of this approach and the need for much greater public awareness of the cost to society when dependent children are separated from their parents, especially by reason of incarceration.

Community involvement is crucial for two reasons. First, the parents and their children need advocates: it is not reasonable to expect correctional staff, whose primary charge is the custody and control of inmates, to play this role. Second, and perhaps more important, it is only as people in the community begin to see prisoners as human beings facing the same types of problems as themselves that genuine support systems for ex-prisoners will begin to be established.

The Prison MATCH program, which has helped create other centers throughout the country, has some excellent practical suggestions of ways in which concerned people can help these forgotten families:

- Individuals who work in or have access to the media can publicize the plight of incarcerated families in a factual, nonsensational manner. As a preliminary, this would mean visiting a prison or jail and talking with the inmates themselves about their children.
- Public welfare professionals can examine their agencies' policies to determine the eligibility of inmates' children for services. Experience has shown, for example, that dispositions about placement of inmates' children are often made without any contact with the mother to determine their needs or without consideration for the children's right to family contact.
- Community agency professionals are in the best position to go into the prisons and develop programs for inmate parents and their children. Prison MATCH has found an extraordinary

willingness on the part of the correctional authorities throughout the country to make this possible.

- Civilian staff — for example, medical personnel — in prisons and jails can find out at first-hand what concerns inmates have as parents and take these concerns to community agencies that deal with children.
- Individuals who work in state or local government are in a prime position to influence policy and funding decisions. Given the enormous social and economic consequences of the enforced separation of parents and children, elected officials should be aware that the support of a program similar to that at Pleasanton may cost as little as \$50,000 a year (the cost of incarcerating two prisoners) and reach 1,000 children.
- Members of religious and service organizations can provide invaluable support to prisoners and their children. In some parent-child programs, volunteers sponsor a mother and her children, bringing the children to visit and being an available contact for them in the community. Others volunteer in the centers themselves or provide transportation for the children and other family visitors.
- Individuals, especially those with needed expertise such as lawyers, can contact existing parent-child programs in their area and volunteer their services. The best way to find out if the state prison or local jail has a program is to speak to the program director at the facility.

Inmates and their children are, in general, an isolated and forgotten group, and they face formidable obstacles to the maintenance of family ties. The programs that have been springing up throughout the country have been able to assist an impressive number of parents and children at relatively small financial cost. Professionals who have had experience with these programs would like to see one in every sizeable prison and jail. As Prison MATCH reminds us, most prisoners, especially women, have children, and most of them will go back to those children. Our choice is whether to give them needed help to maintain and improve their relationships and to return to the community with new skills and an enhanced self-image or to continue to ignore them and their children.

DISCUSSION

Ellen Galinsky: What effect do you think the nursery program at Rikers Island has had on the relationships between the mothers and their children?

Margaret Wishart: The mothers seem very positive. If they have had other children, they usually have never had the opportunity to give undivided attention to a baby. At Rikers they don't have to cook a meal, they don't have to shop, it's all brought to them. It's a very unnatural situation, in a way, and that worries us somewhat. They are often going to go from the luxury of the nursery to the care of several other children, perhaps to crowded apartments with no hot water.

Sandra Scarr: At Bedford Hills, do the babies have to leave after twelve months?

Margaret Wishart: No, at Bedford they leave after eighteen months. That's an issue. Clearly, keeping the baby for eighteen months gives a lot more time to plan for the future than having the child taken away at birth. But the parting must be terribly hard on the women. If a woman is getting out in, say, another few months or so, they may stretch it a little bit. But there are women who are at Bedford for fifteen years. At Rikers the babies stay for one year, which isn't so bad, because in theory nobody stays at Rikers for more than one year, although sometimes inmates with complicated cases do stay longer.

Bettye Caldwell: Did you say that the prison population has increased 40 percent or 14 percent since 1980?

Margaret Wishart: Forty percent. This country locks up more people per capita than any other country except South Africa and Russia. Many people here honestly believe that if you lock up a miscreant or a convict you are going to reduce crime. I think many people are unwilling to look at the reasons for crime and what other measures might be taken to restrain it.

One of the things that strikes you at a place like Rikers Island, which is the largest penal institution in the United States, is that you rarely see white faces when you see groups of inmates walking by. The inmate population is predominantly minority. There were two studies done at the New York City Department of Correction within the last ten years, and they both have the same findings: that about 62 percent of the inmates were black, about 24 percent were Hispanic, and the rest were white and other. I think if we did a study today there would

be some changes. We do methadone detoxification at Rikers Island for the large substance-abuse population, and the figures that I report to the state every month are beginning to show almost a complete reversal between the black and Hispanic groups.

I was interested in what Juanita said earlier about the importance of understanding people's cultural background. I don't think that we have even begun to come to grips with understanding the expanding Hispanic population. I believe our providers, especially our medical providers, need to be educated about the Hispanic culture and to realize that Latin American culture is not monolithic but that there are profound differences among the peoples from the different countries.

Sandra Scarr: With respect to the prison population, one of the features of the United States system is that we give people longer sentences than most other countries do. People stay in prison longer, which has implications of course for their relationships with their children and for child care, but it also means that at any one point your census is much higher.

Betty Caldwell: Thank you, Margaret. I don't know about the rest of you, but I feel so tense, hearing this and thinking that I personally have never done anything about this problem, that I didn't even know about it. This has been a real educational experience for us all, Margaret, and we do appreciate it.

CHILD CARE AS A SETTING FOR PARENT EDUCATION

Michael W. Yogman, M.D.

The people who provide supplemental care for young children have the potential to provide both support and education to parents. This paper describes the factors that determine the degree to which that role of providing support and education is realized and the kinds of

support, skills, and knowledge that parents can find in an optimal child care setting.

Parent participation in child care can be of at least three kinds: *didactic education*, *political involvement*, and *interpersonal involvement*. Didactic education is found in formal programs of lectures and group meetings on topics such as child health, nutrition and safety, child development, and child-rearing. At its best it can be very supportive to parents, but at its worst it can subordinate parents, heighten their feelings of inadequacy, and place unacceptable demands on their time. Several studies (Powell, 1978; Radin, 1972) have found participation in didactic groups and conferences not to be broad-based. Political involvement refers to parental involvement in policy-setting and administration of a center. Parents may serve on a board of directors or advisory panel, providing input into policy decisions regarding curriculum, values, and staff hiring. Such involvement gives parents greater feelings of control over the supplemental care of their children, but it is an option open to only limited numbers of parents.

This paper will focus on a third, much neglected type of involvement, the interpersonal involvement between parents and supplemental caregivers. In contrast to didactic education, the exchange of information here is informal and individualized and depends on two-way communication in an atmosphere of mutual trust and respect. Such a partnership can strengthen parental feelings of adequacy and self-confidence, can facilitate the transfer of information about a specific child between parent and teacher, and can foster the individualized care of each child. When this kind of parental involvement is not going well, however, parents can report considerable anxiety and tension about both their child's and their own relationship with the teacher. This paper emphasizes several factors that facilitate the development of a positive working relationship between parents and caregivers.

The Objectives of Parent Education, and the Outcomes

Parents today are psychologically stressed, conflicted, and uncertain about the balance between personal fulfillment and self-sacrifice on behalf of their children. A Carnegie Council report (Keniston & the Carnegie Council, 1977) captured these new worries:

[They] wonder whether they're doing a good job as parents, yet are unable to define just what a good job is. In droves

they seek expert advice . . . What is new . . . is the intensity of the malaise, the sense of having no guidelines or supports for raising children, the feeling of not being in control as parents, and the widespread sense of personal guilt for what seems to be going awry (pp. 3-4).

In view of these parental feelings of isolation from other sources of support and education such as the extended family and long-term neighbors, the potential of the child care setting to provide parental education and support takes on increased importance.

The degree of parent participation and education in child care programs involves choices by both professionals and parents. Bronfenbrenner (1975) has posed the question of what kind of child care will be offered. Will the care of young children be delegated to experts, reducing the family's feelings of responsibility for their children? Or will child care be designed to strengthen and involve the family? Teachers express concerns about parent involvement and participation, suggesting that they do not find collaboration with parents easy (Steiner, 1976). Parents must also decide where to seek education and support: at a child care center, at the pediatrician's office, or at a seminar at the workplace. They must make choices about their use of limited time, their own needs for education and support, and the attractiveness, practical value, and availability of such programs.

Parent education in child care settings has two objectives: first, to support parents by enhancing their confidence, reducing their feelings of anxiety, tension, and guilt, and improving the knowledge, skills, and attitudes that contribute to their own care of their children; and second, to improve child outcomes, intellectual and social, as a result of enhanced and ongoing parental education of children at home. Research into whether these objectives have actually been met has not shown clear-cut effects. Most research programs have combined didactic education with individualized staff interpersonal involvement and have demonstrated such beneficial effects on parents as positive changes in how much mothers teach, talk to, and interact with their children (Levenstein, 1977; Gutelius et al., 1977; Bromwich & Parmelee, 1979) and on maternal attitudes (Radin, 1972). But while many believe that more self-confident, knowledgeable parents who interact more positively with their infants will rear more competent children, research has not yet convincingly demonstrated the impact of parent education on improved child outcomes. Reviews of parent education as a mediating variable in understanding the positive effects of early education on children's intellectual development and social

competence have offered conflicting answers (Clark-Stewart & Fein, 1983). In assessing effects on intellectual development even in center-based programs that placed a special emphasis on parent education, changes in parental behavior have not been shown to precede increments in children's performance (Kessen et al., 1975).

Access to parents has often been achieved with a home visiting component. Most evaluations of the Head Start project suggested that in order to have a lasting constructive impact on the child's development, programs need to work not only with the child but with the parents caring for the child at home on a day-to-day basis (Bronfenbrenner, 1975). Bromwich and Parmelee (1979) even in a home-based program showed no effects on child cognitive outcomes, while Radin (1972) showed no contemporaneous effects but did show effects on children's language development a year later. Almost no programs have assessed the potential beneficial effects of parent education on children's social development. Better research is needed to determine the conditions under which parent education (particularly informal, interpersonal involvement rather than didactic education) is an essential mediating variable in producing sustained effects on children and those in which direct work with children can be a more effective means to positive child outcomes.

Staff-Parent Relationships and Their Impact on Parent Education

Programs in parent education in various settings have been based on a number of assumptions. Four such assumptions have been suggested by Caldwell (in press):

1. Parental behavior is not primarily instinctual but is learned and can be modified by education. Considerable evidence (Levenstein, 1977; Gutelius et al., 1977) supports this assumption.
2. A knowledge base regarding effective parenting exists, and ongoing research will improve this knowledge base.
3. Parental emotions and attitudes are as important an ingredient of parenting as the knowledge base and must be addressed in any education program. In a child care setting, parental emotions may even be heightened; sharing the care of one's child with another adult is likely to produce anxiety and even guilt.

4. Everyone needs help with the stress of parenting. The need is intensified by current life styles and the lack of support parents feel in our culture.

To these four assumptions I will add a fifth, which is particularly pertinent to parent education in a child care setting: the degree to which parents can learn from the people caring for their children depends largely on the ability of parent and caregiver to develop a positive working relationship. The development of such a relationship is not always easy. Working with young children in any capacity elicits in all adults a desire to protect the child from adverse events, and professionals working with young children often feel competitive with parents in protecting the interests of the children. One can suggest at least four ways to minimize this problem:

1. Make explicit the differences in roles between child care provider and parent. Each must be helped to see and respect the unique strengths of the other and to understand the value of working cooperatively.
2. Emphasize and support the role of the child care provider as an advocate for the child's relationship with the parent. It is too easy in our culture to focus on parental weakness and on protecting the child from the parents rather than supporting the dyad. Parents have unique insights and experiences with their children that can be most helpful to the child care provider.
3. Whenever possible expand the dyad to a triad that includes the father, even if unmarried. While fathers now play an increasingly active role in hospitals and at home with young infants, they are all too absent from child care and school programs (Yogman, 1983). Imaginative, active outreach to fathers as well as to mothers, including offers of practical help, can increase the level of involvement by both parents. An initial home visit to collect in-take information prior to the child's entering the program may engage both parents and encourage active participation.
4. Make the techniques and skills of working with parents an important part of teacher education and in-service training programs (Almy, 1982). Training in interviewing skills is needed, along with a knowledge of parental defenses and adaptations, parent development, and the changing needs of parents.

Dimensions of Parent Education

Education has been divided into three domains: attitudes, knowledge, and skills. It is important to note that knowledge alone does not define education. Attitudes and emotions as well as skills influence parental reasoning and judgment and should be a major part of any parent education program. All three domains can more easily be included in a program that emphasizes informal interpersonal involvement by parents rather than didactic education.

Parental attitudes and emotions. When children first enter a child care program, parents may need considerable help with their own feelings of anxiety and guilt, especially if the child cries when being left. The staff needs to feel comfortable supporting parents during normal entry and exit transitions as well as during more stressful crises. When parents understand their own feelings, they are better able to respond to the child's needs rather than to their own.

The end of a day in child care is another time that may be quite stressful for parents. At the end of a busy day, the child may be quite irritable. Preparing parents in advance to expect this discharge of tension when their child arrives home may help them cope with this situation. Crises such as childhood illnesses, even minor ones, may provoke parental anger and its displacement to staff. Familiarity with variants and stages of parental grieving in response to even minor illness can help the staff support the parents through such a crisis.

In addition to the efforts of staff members, parent groups can provide informal support and can spark the creation of more extended parent networks for ongoing support. Parents of older children who have graduated from the center can be invited back to offer their perspective and coping strategies.

Parental knowledge. The opportunities for transmitting information to parents about their children are almost unlimited in child care settings. Information about normal parent and child development, child rearing, management of child behavior, child health, and safety issues can all be shared with parents in group meetings and newsletters. Resource tables and bulletin boards can offer information in pamphlets and research reports. A lending library or reading shelf can offer books on child care as well as children's books. More important than general information is the opportunity for the teacher and parent to share specific information on an individual child, through personal contact or written or telephone communication. Blackboards and/or

notebooks enable parents and teachers to communicate specific information on a child on a daily basis.

If parents have the time, guided observations or cumulative records of the child's activities can offer another useful communication medium. When parents can visit the child care program and can observe both their own and other children during interactions with each other and with adults, emotionally laden concepts such as the clinginess of a one-year-old and the independence, negativism, and need for consistent limits in a two-year-old become more generalized and objective. Furthermore, parents can view their child's strengths and coping skills during interactions with peers and novel adults, can see cognitive skills during problem-solving tasks, and can recognize the self-protective aspects of regressive behavior after separations and stressful transitions such as change of class or teacher. Guidance and clarification of such observations can ensure that they are positive and informative experiences for parents.

Parental skills. The child care program offers parents a unique opportunity for education in parental skills. Parents present in the center can observe their child's responses to other people and the styles of other parents and teachers with other children and with their own. They can then model their own behavior on what they have seen and learn new ways of social interaction with their infants. They can also observe the way teachers facilitate a child's problem-solving cognitive skills as well as conversational skills. Observing the excitement in a child's discovery of hidden objects or of cause-and-effect rules can reinforce the good feelings parents have about their child and motivate them to facilitate these cognitive skills further. Finally, parents can use the resources of child care programs to develop advocacy skills on behalf of children, perhaps bringing about the development or expansion of community services that may benefit the child long after leaving the program.

Encouraging Involvement in Parent Education

Child care programs should recognize a number of factors that will influence the degree to which parents become involved with the program. First is the demands that a center makes on the parents' time. Since many parents have little time to spend in the center, it is often more effective to maximize communication at the morning and

evening transition points rather than to add activities. Second, staff policies can either foster staff-parent communication on an informal basis or discourage it. Powell (1978) suggests that a consistent primary teacher be identified for each child and that this teacher be freed up and encouraged to meet with the parents at transition times. Optimally, private space should be available for confidential communication. These recommendations may be costly in terms of extra staff and space, but the extra costs are necessary if such communication is desired. Third, centers must remain flexible enough to encourage the involvement of all parents whose children are enrolled in the program. Many programs serve a diverse group of parents with varying needs and preferences with regard to parent education. Appointing parent advocates may even be considered as a way of ensuring that parents' needs are addressed by the staff.

One of the objectives of this conference has been to emphasize that child care is a supplement to rather than a substitute for parental care. It follows, then, that the goal for child care should be to support and augment the primary role of the parent with the child. The potential for parent education in child care settings is great, but so are the problems. The support and training of child care staff are critical for it to be realized.

DISCUSSION

Robert Rock: Mike, if you could set up a way to educate parents, or a parenting program, how would you recommend doing it?

Michael Yogman: Most important of all, I would free up the staff to meet with individual parents at least once or twice a week when they come to pick up their children. These frequent informal contacts in which parent and teacher discuss the individual child on a one-to-one basis are the most important vehicle for parent education. Training programs should emphasize the supportive partnership between parent and teacher rather than didactic education. We need to learn more about how to train child care providers in the skills of working with parents, because that is likely to have the greatest payoff in providing opportunities for parent education in child care settings.

Sandra Scarr: Craig Ramey at Project CARE incorporated parent education, as you know. This staff was highly trained and worked very hard with the parents. They had good communication with these low-

SES (socio-economic status) parents. They felt they were supportive, and in fact many of the mothers went out and got jobs, which they hadn't had before, or went back to school, and in terms of the kind of Head Start outcomes, this was a fairly successful program for parents. But the parent education component of it was totally unsuccessful. Parent education added nothing to the outcome for the child.

Michael Yogman: In Project CARE, didactic parent education — that is, a curriculum and site of delivery — was the major programmatic difference between the groups being studied. The two groups received comparable parental support and informal contact between parents and staff. Therefore, it is not surprising that no differences were found in intellectual function. The outcomes measured were almost entirely cognitive, with very little assessment of social competence. Also, our goal is not just to enhance child outcomes; our goal is also to support parents as an end in itself. Parent education defined in a broad way is a crucial support system for stressed families, and that includes just about everyone.

Sandra Scarr: I agree with what you're saying. It's just the didactic part of it that has not proved especially successful, and it was that portion that I was challenging, not really the whole thing.

Susanne Martinez: From a public policy point of view, most policy makers tend to read a research abstract simply in terms of whether something was a success or a failure. Especially in this area of social science, researchers have to be really careful, in doing preliminary studies, that they don't create ambiguities that people will seize on. I think we saw that in the late 1960s with Head Start. The IQ scores didn't rise, and we were about to abandon the program until someone said, "Hey, wait, there are other things we should be measuring." There is a lesson there for parent education.

Susan Aronson: In fact in that study they were not making a fair comparison of parent education versus no parent education, because child care itself is a very wonderful, rich source of parent education. I would take it even a little further and argue that whether or not there is any direct training of the caregivers in communicating with parents about child development or other subjects, the modeling opportunity is itself one of the most effective means of communicating with and educating parents, especially if it is reinforced verbally.

I would also suggest that you could ensure parent commitment in the program by requiring parents to spend transition time with the caregiver.

Betty Caldwell: We tried such a contract in both Syracuse and Kramer, and frequently you find yourself in the moral dilemma of penalizing the children. You sometimes end up excluding the children who need the supplementation the most, because the parents won't participate.

Susan Aronson: But you can make it clear that it's an expectation and help people understand why it is valued. In a way, the child care program provides a parental type of support for the parents' needs. That's not to say that you usurp the parents' responsibilities, but adults don't lose their dependency needs by becoming adults, and we may need to help some parents see that this is a valuable interchange.

Elinor Guggenheimer: We were troubled way back when about the word *education*. We talked at that time about *parent participation*, so that the staff in a program would not feel paternalistic or maternalistic. I liked your point about the caregiver having a lot to learn from the parents; the parents know the child better than anyone else.

The matter of observation also interested me, because observation is complex. If you haven't helped the parents to understand what they are observing and if their child is not doing as well as some other child, you may be creating tensions you're not aware of.

Ellen Galinsky: There are two interesting projects that are concerned with measuring outcomes. One is the Harvard Parent Support Project, which is looking at how we evaluate parent support. The other is Douglas Powell's evaluation of the MELD Project, which is going to look at some different ways to measure it.

Rebecca Fewell: I thoroughly endorse the dimensions of parent education that you describe. In handicapped education, the only dimension in parent education has been the parent as teacher; the outcome measure was the change in the child's behavior: could the child stack more blocks after you had this parent involvement program? That, we know, is an inappropriate measure for parent education, so I'm delighted to see your concerns listed differently.

I was also glad to see your emphasis on fathers. Several years ago I became concerned that parent involvement as required for HCEEP grants was actually mother involvement and that we needed to do something about it. We put in a grant to serve fathers, grandparents, and siblings. We wrote them up as minority groups as far as early education was concerned. We looked at such things as stress, coping, increasing the networks, families' access to more community resources, their increased knowledge of child development, their plans for the

future. I'm glad to say we have been very successful over a five-year period in significantly reducing stress in the families that had access to fathers' services versus those who had not. We were even able to show significant differences in the wives of the husbands who had access to the services, in terms of coping and decreased depression.

Ellen Galinsky: Often if one parent participates in a program and the other doesn't, there can be a real problem in making a change. One parent will learn something, but no one thinks about helping that parent bridge the cultural differences that are created within the family when that knowledge is applied.

Juanita Fleming: I think that the informal kind of parent education is very important. There may be other things that you could add to it. A lot of people are getting home computers, so you can leave messages for parents on the home computer if the center has a computer, as some of them do. Also, if you're community-minded and you have something that you really want people to know about, you might look at public service announcements on television. I'm just adding two more to your strategies.

Ellen Galinsky: I want to emphasize the mutuality, the fact that the caregiver has something to learn from the parent just as the parent has something to learn from the caregiver. I've done some very successful programs in which parents came and shared their expertise. For instance, last year's parents came in and discussed with new parents the transition to child care at the beginning of the year.

I think that we should work toward having parent advocates in child care settings, someone who could learn to take the parents' perspective, who would help others gain the skills they need to work well with parents.

We need to consider parents' developmental needs, just as we consider children's developmental needs. For instance, taking over for the parent or being the expert for the anxious parent is probably one of the most harmful things we can do, even though it may make us feel better as the expert.

Dana Friedman: There are probably 1,500 companies across the country who hold parent education seminars at the workplace. These allow parents to think about parental stress in the context of other stressors on the job, and they also sensitize the company to family needs. Parents often don't have time to participate in events at the center in the evening, so these seminars at the work site are often a useful idea.

PART II
OBTAINING SUPPORT
FOR CHILD CARE

CHILD CARE AND PUBLIC POLICY

Susanne Martinez, J.D.

The United States has no national policy on child care nor anything that even resembles a coordinated approach for addressing the issue, despite the fact that the federal government currently expends over \$2 billion on a child care program — the IRS child care tax credit — which primarily benefits moderate- and upper-income families. Over the past five years, the federal government has withdrawn financial resources from child care programs that assist low-income families seeking to attain economic security and self-sufficiency and has abdicated any responsibility for helping to assure the quality and safety of child care programs. As a consequence of this withdrawal of resources and leadership, the availability and quality of child care services for those most in need of government help has substantially deteriorated.

Recent scandals involving the protection of children in child care programs have generated renewed concern and interest at the national

level. This paper reviews recent federal legislative activities in the area of child care and describes current initiatives to expand the role of the federal government and bring about a better and more equitable system of support and quality.

The Absence of a National Policy on Child Care

Despite the statistics demonstrating a dramatic increase in the need for child care services for working parents, the United States has no national policy regarding child care, nor anything that even remotely resembles a coordinated approach to dealing with the escalated demand for child care. Indeed, child care has always been a neglected subject. During several periods in our nation's history the federal government has been involved in supporting child care programs, but in each case that involvement was in response to some other pressing need. For example, during the Depression, a day care program was established under the Federal Emergency Relief Administration (subsequently the WPA) to create jobs for unemployed adults. Funding was decreased as the economy improved and adults were able to find jobs in the private sector. Similarly, a federally funded day care program was established during World War II under the Lanham Act to enable women to work in war-related industries. Most of the programs established under this program closed immediately at the end of the war when the women were no longer regarded as needed in the work force.

In the early and mid-1960s, federal financial support for child care programs was authorized under the Social Security Act for welfare mothers participating in work programs. Again, the impetus — discouraging welfare dependency — was in response to adult needs rather than part of a long-term commitment to supporting children and families (see Norgren, 1981).

In many respects, the high and low points for child care at the federal level occurred in the early 1970s when Congress passed a far-reaching, comprehensive child care bill, authorizing \$2 billion to fund construction and operation of child care centers (Title V, Economic Opportunity Amendments of 1971, S. 2007). That legislation was passed by Congress with the support of a broad coalition of organizations, only to be vetoed by President Nixon — a veto that has impeded child care efforts at the federal level to this day.

What was devastating to child care was not only the veto but the

rationale that the president set forth for it. Nixon's veto message condemned government support for child care on the grounds that it would diminish parental authority and involvement with children and lead to what one opponent described as the "sovietization" of child-rearing in this country.

In 1975 another child care bill, proposed by then-Senator Walter Mondale, was crushed under a right-wing mail campaign attacking the legislation in the same terms used by Nixon, again alleging that support for child care was a step toward "sovietization" and communal child-rearing (Subcommittee for Children and Youth, 1975). In 1979 yet another child care bill, this time proposed by Senator Alan Cranston, was assaulted with the contention that such legislation "invaded the privacy of the family and [was] detrimental to the rights of parents" (Guardians of Traditional Education, 1979).

Although a number of child care initiatives have been introduced in the 99th Congress and two small child care bills were enacted at the end of the 98th Congress, the prospects for developing any type of coordinated federal policy with respect to child care remain dim. Instead, child care advocates at the national level have concentrated in recent years upon strengthening the existing patchwork system of support.

Federal Support for Child Care

Prior to 1981, several different federal programs provided financial assistance to certain groups utilizing child care services. The principal source of direct support for child care services was Title XX of the Social Security Act, which provided states with block grant funds to meet the social service needs of a variety of groups, ranging from foster children to elderly and disabled individuals. Child care was one of the major activities for which Title XX funds were used, and it has been estimated that prior to 1981 approximately 21 percent of all Title XX funds were expended on child care services (Committee on Ways and Means, 1985). States were required to give priority for Title XX services to families receiving welfare assistance. But although Title XX was and continues to be a significant source of support for child care, it is not a child care program. It is a general social services/social welfare block grant program, and child care is in constant competition with other programs and other constituencies for scarce resources.

Child care programs also received some assistance through pro-

grams like the child care food program operated as part of the National School Lunch program and through subsidized employment programs operated under CETA. In 1984, \$357 million was appropriated for the child care food program, and it was estimated that more than one million children between the ages of three and five participated in this program, which subsidized the cost of food services in participating child care centers and homes (Stephan, 1985).

The Head Start program, although not a child care program, provides federally funded child development services to low-income children. Only a small number of Head Start programs — currently less than 15 percent — provide full-day services. In 1984, approximately 434,000 preschool children were enrolled in Head Start programs; the federal government appropriated a little more than \$1 billion in fiscal year (FY) 84 to support this program (Stephan, 1985).

Indirect federal financial support for child care was provided through two mechanisms. First, employed AFDC (Aid to Families with Dependent Children) recipients are allowed to deduct the costs of child care when computing the amount of welfare benefits they are eligible to receive. This AFDC - child care expense disregard has never served as a particularly effective way to provide child care assistance to AFDC families. One principal reason is that like the tax credit described below, it is not available in advance to help pay for child care costs; the recipient simply receives an adjustment in subsequent benefits for the costs of securing child care that enables the recipient to work. With housing, food, and medical needs of a family to be met on a limited budget, many AFDC recipients are hard-pressed to find the money to pay for adequate child care. Also, limitations on the amount expended on child care that can be disregarded — regardless of the actual costs incurred — have been unrealistically low. In 1981, the maximum allowable disregard was limited to \$160 per month per child (Public Law 97-35, Title XXIII).

Second, since 1976, families with income tax liabilities have been eligible to use the child care tax credit. Prior to legislation enacted in 1981 to expand this credit and target more of the benefits toward low-income families, most of the benefits from the tax credit went to moderate-income families. In 1979 almost 80 percent of the tax credit was claimed by families with incomes over \$15,000 (U.S. General Accounting Office, 1982).

Changes in Federal Involvement in the 1980s

The 1981 budget cuts slashed deeply into what had already been an inadequate system of support. Title XX was cut from \$3.1 billion to \$2.4 billion, and provisions earmarking a portion of Title XX funds for child care were eliminated. Other programs that had provided support to child care were either wiped out entirely or drastically cut.

The impact of these cutbacks on child care programs was devastating. One state-by-state survey in 1983 found that 32 states were providing Title XX child care to fewer children than in 1981, despite increased numbers needing such care (Children's Defense Fund, 1983). The total combined federal and state spending for Title XX child care dropped by 14 percent between 1981 and 1983, and numerous states imposed or increased fees, making it harder for low-income working families to afford Title XX child care.

At the same time that massive cutbacks were being inflicted upon the programs that provided direct support for child care programs, the child care tax credit was significantly increased (P.L. 97-34, sect. 44A, IRS). A provision that would have made the credit refundable, however, and thereby reach the lowest-income families was passed by the Senate but rejected in conference by the House of Representatives. Therefore, although the child care tax credit today provides the single largest source of federal funding for child care, low-income working families receive the least benefit from this credit (Stephan, 1985).

The tax code was also clarified to permit employers to provide employees with child care assistance through tax-free dependent care assistance programs (P.L. 97-34; sect. 129, IRS). These programs, like the child care tax credit, tend to be of greatest benefit to higher-income employees, since they operate to reduce taxable income.

It is ironic, therefore, that in the first half of the 1980s, federal support for child care for lower-income families has been drastically curtailed, while higher-income families have been benefited by expanded tax code provisions. Clearly, the indirect, tax-code approach seems to be less vulnerable to the type of right-wing opposition that has halted previous efforts to expand direct assistance for child care.

Signs of Progress in the 98th and 99th Congresses

Despite the cutbacks in child care programs enacted in 1981, some limited progress has recently been made in restoring funds to existing programs and authorizing several new programs.

First, Congress restored some of the funds cut from the Title XX program. In FY 85, Title XX funds were increased to \$2.725 billion, and both the administration's FY 86 budget proposal and the First Concurrent Resolution on the 1986 Budget approved by Congress provide for funding for Title XX at \$2.7 billion.

Second, in the closing hours of the 98th Congress, legislation authorizing the establishment of a small — \$20 million — dependent care block grant program was approved. This new program, included as part of the 1984 Human Services Reauthorization Act, P.L. 98-558, authorizes grants to be made to the states to support establishment of school-age child care programs and dependent care information and referral programs. Five million dollars was appropriated by Congress at the end of 1985 to start the new program.

Third, responding to public attention on several cases involving sexual abuse in child care centers, Congress approved an additional \$25 million for Title XX to be earmarked for child care training programs, particularly child abuse prevention training. In order to receive full funding under these provisions, states are required to adopt procedures for conducting checks on the background, employment history, and criminal records of prospective and present employees of child care programs. Although these provisions were adopted without committee action or hearings and have been subject to criticism as representing a hasty response to media coverage of isolated cases, they do represent congressional recognition of a need for national leadership in the area of child care.

Despite the apparent progress in several areas, federal support for child care continues to exist under constant threat. For example, the Reagan administration's FY 86 budget proposed changes in the child care food program that would eliminate federal support for meals served to an estimated 23 percent of the children in child care centers and substantial numbers of those in family day care homes (Stephan, 1985). Additionally, the original Reagan tax reform proposal would have converted the child care tax credit to a deduction, which would be relatively less favorable for low-income families than the tax credit.

On a positive note, a number of new child care initiatives have recently been introduced in both the House and the Senate, covering a broad range of issues. On March 28, 1985, six senior senators — Alan

Cranston (California), Dennis DeConcini (Arizona), Christopher Dodd (Connecticut), Gary Hart (Colorado), Edward Kennedy (Massachusetts), and Donald Riegle (Michigan) — jointly introduced eight separate child care bills. These measures would provide for additional funding for child care under Title XX (S. 803), establish a scholarship program for obtaining a Child Development Associate (CDA) credential (S. 804; see Smith, this volume), provide child care programs in housing projects (S. 805), improve and expand the new dependent care block grant program (S. 806), authorize a program to provide supportive services for family day care providers, including training and technical assistance (S. 807), provide grants for school-based child care and early childhood education demonstration projects (S. 808), provide financial assistance for child care services for college students (S. 809), and provide assistance to states in improving child care standards and monitoring (S. 810).

Legislation dealing with many of the same areas (H.R. 2867) has been introduced in the House of Representatives by Representative George Miller, Chairman of the House Select Committee on Children, Youth, and Families, following a year-long series of hearings and a comprehensive report on the need for federal action in the child care area. Finally, major child care initiatives were included in the 1985 Women's Economic Equity Act (S. 1169, H.R. 2472), the omnibus, bipartisan legislation covering a broad range of economic issues affecting women.

The Child Care Standards Issue

Much of the current interest in Congress in child care issues seems to have been triggered not so much by a growing awareness of the increased demand for child care services but rather by public concern over media reports of problems such as sexual abuse in child care programs. That coverage has served to focus the attention of the public and policy makers on the issue of child care licensing and monitoring.

Although all states require child care centers to meet some licensing requirements and most regulate family day care homes in some fashion, these requirements vary tremendously from state to state. Restrictions on the number of children cared for by each adult, for example, is a critical factor in assuring the quality of care provided. The number of children under one year of age who can be cared for by

one adult ranges from three or four in some states to as many as eight in others. Qualifications and training of child care workers and those who supervise child care centers is also critical to the quality of care. Again, states vary widely in their requirements for center directors and caregivers. And while the right of parents to have access to programs is important in monitoring care, only five states specifically require that parents have unlimited access to child care centers (U.S. Department of Health and Human Services, 1985).

This dismaying lack of uniformity and the wide gaps in state standards for child care result, in large part, from the withdrawal of federal resources and leadership in the past five years. Prior to 1981, the federal government did have a set of federal minimum standards for federally funded day care. Those standards, the Federal Interagency Day Care Regulations — FIDCR — had been in effect since 1968. In 1978, Congress was provided with the results of a comprehensive report (U.S. Department of Health, Education and Welfare, 1978) supporting the need to continue to require states to comply with federal minimum standards for federally funded day care programs and suggesting areas where the 1968 standards could be improved.

Between 1979 and 1980, much effort went into updating and revising the 1968 standards along the lines suggested in the 1978 report. The final regulations were published in the Federal Register in March 1980 and enjoyed wide support. In June 1980, however, Congress voted to suspend enforcement of those standards. The principal argument made against the new standards was that they *might* result in increased federal welfare expenditures in that states would be required to reduce child-staff ratios and that some families would therefore be excluded from child care programs and forced onto welfare, resulting in increased federal welfare costs.

The tragic consequences of this withdrawal of federal leadership and policy guidance have been readily apparent. In 1981, freed from federal minimum requirements and facing severe cutbacks in federally supported programs, many states simply cut back on child care standards and quality controls. The Children's Defense Fund (1983) found that thirty-three states had lowered their child care standards for Title XX-funded programs and twenty-four had reduced funds for training of child care workers. The CDF report noted numerous instances of cutbacks of staff carrying out child care licensing and monitoring activities.

Edward Zigler wrote in the *New York Times* on July 30, 1985 that without minimum federal standards "we run the risk of scandals like those in the nursing home field that have periodically shocked the

country." That prophecy has certainly come true. The nation has been rocked by just such scandals. But the scandals have also drawn public attention to the need to address the more basic issues relating to the quality of child care programs. Parents of all income levels need to know that the centers and homes that are caring for their children are safe and adequate places for young children. Government licensing and monitoring programs alone cannot guarantee the safety and security of these children, but they can contribute significantly to ensuring that the goals of safety and adequacy are met.

DISCUSSION

Sandra Scarr: Would you elaborate a little on the eight new initiatives that have been introduced in the Senate, and what you think their fate might be?

Susanne Martinez: One of the strategies that was worked out between the six offices was to break apart the different issues in the area of child care so that each could be addressed in a separate bill. The eight bills developed in that process were designed to be referred to different committees. Having different lead sponsors for each bill meant that the work could be spread around and different lead senators would be able to concentrate on different bills.

Another concept underlying this strategy of separate but related legislation was that by introducing the bills at the beginning of the 99th Congress, we would look at the Congress as a two-year session and try to move different pieces of the legislation at different points where an opportunity arose.

At this point there is some favorable activity going on as a result of that strategy. Senator Kennedy may try to get some of the provisions of his legislation relating to child care for college students worked into the reauthorization of the higher education bill. That legislation is currently being moved through the committees. In the bill that Senator Riegle has been working on, the Public Housing Bill, a small portion of that has been included in the housing reauthorization. We will continue to watch in the next year for similar opportunities for other bills.

Judith Palfrey: How does the budget reduction affect the new initiatives?

Susanne Martinez: It will have a devastating effect. Any program that involves federal funds will be affected. The program can be authorized but lose all funds. In the peculiar process we have, initiatives first are authorized and then they are funded in a subsequent action. Sometimes a program is authorized and not funded, but that authorization will sit there until a more favorable time, and then funds can be appropriated for the program. It's a long, tedious process.

Dana Friedman: What are the implications of the fact that we now have a Senate Caucus on the Family, a Senate Caucus on Children, and a Select Committee on Children, Youth, and Families? Is that raising consciousness? What effect if any is it having?

Susanne Martinez: It's hard to tell. The Senate children's caucus in particular has provided a place for members who are interested in children's issues to meet and work in a less structured setting. Normally, committees can look only at issues in their jurisdiction. The caucus, which now must have over twenty members, can look at cross-cutting children's issues; it is not restricted by the limitations of committee rules and Senate rules. I think the formation of the caucus is an encouraging note. The House committee certainly has provided a forum for gathering information and focusing attention on children's issues. There have been activities such as the report on child care, a bipartisan report signed by all members, which have been particularly useful.

Susan Aronson: You highlight well the "trilemma" that we mentioned yesterday and that Gwen Morgan brings up about the tension between cost and quality. Of course, the third piece for her is caregiver wages, which by being so depressed are driving people out of the field and keeping the quality of child care down. It is very hard for people to stay in the field and provide continuity. Those are very important related problems that we have not solved.

Regarding the issue of standards, we have a number of different models for standards in this country. We have voluntary standards and mandatory standards. Voluntary standards have been the way of the more recent past. Our current climate is to try to involve private industry and get them to adopt things that may not be imposed upon them. I want to comment about the important effort that is being undertaken in child care with the Academy Program of NAEYC. It is an important step forward. Unfortunately it will not affect the many programs that are not reaching for that level of excellence, however, and it will not solve our problem of making the child care community

aware of at least the minimal level of safety needed for children. I do think we need to work toward some kind of mandatory program.

I have very little optimism about training parents to be the monitors. We have enough difficulty teaching parents to monitor their own home environments for safety. To make a parent who has few options, other than the child care program used at the moment, come in and challenge the child care program about the level of safety or quality they are maintaining is asking a lot of a parent.

I did a study back in the late 1970s in which I was providing training to child care staff on health and safety issues. One of the things the study found was that child care staff generally want to do the right thing. If you simply make them aware of what the right thing is, they will generally try to do it. Therefore, monitoring that brings the attention of people working in the child care environment to ways they can improve the quality of care for children is one of the cheapest forms of technical assistance that we can provide. I would urge that we consider monitoring as a form of training and technical assistance and approach it as another avenue to try to bring up the quality in child care.

Michael Yogman: I've come up with a rather off-the-wall idea about the federal government's suspension of the FIDCR. A legal campaign has been initiated against the cigarette industry to hold them liable for the health consequences of smoking, as public policy. I realize the complications of trying to hold public policy makers of the federal government liable for the consequences of their action. But is there any way to tie the whole quality issue and what is happening in this sexual abuse business to an actual change in public policy?

Susanne Martinez: I don't know of any ongoing litigation approach to the issue, but there certainly is discussion about where we are five years later because of this abdication of responsibility.

Dana Friedman: I think there was a suit against a family day care provider in California; the parents sued the provider and the state of California in the case of the death of a child, because the state had monitored that home six months before. It would be a state issue, not federal, since we don't have federal standards.

Susanne Martinez: There is a line of legal authority. For example, if you eat a can of tuna that has not been inspected properly, there is liability for the government entity that was responsible for inspecting it. I'm not familiar with that case in California, but it sounds like an interesting concept to pursue.

PUBLIC SUPPORT FOR CHILD CARE

Elinor Guggenheimer

The Child Care Action Campaign is a coalition of civic and business leaders, representatives of the media, heads of major women's organizations, and nationally recognized child care experts. It was formed for the purpose of stimulating wide public support for child care services.

Although there are a variety of resources and types of child care programs in existence, the supply falls far short of the demand for services. Other problems in child care include affordability and accessibility as well as the monitoring and maintenance of quality standards. Public support is needed to bring about improvements and begin implementation of an orderly system of child care services. The United States is the only industrialized country that has no such system in place.

Some negative images of child care are proving a barrier not only to public support of child care but to the ability of child care providers to obtain liability insurance. This paper outlines the need for a major marketing effort to improve the image of child care and obtain the support of government at all levels and of the public at large. It describes strategies the Child Care Action Campaign is using and that others in the field can use toward meeting that goal.

The Child Care Action Campaign

The Child Care Action Campaign is a new type of organization. It wasn't started by child care workers or providers.

In one week in 1983, three cases came to my attention. One was the arrest of a couple in Brooklyn who had lied about their income in order to get their children into the only existing child care service in the area, which was a Title XX program. Had they not lied, they would have had to pay \$85 a week per child. They both worked, they had three children under the age of five, and their income was \$27,000. The

New York Times reported that they could get as much as seven years in prison.

Second, a friend of mine, a single mother with a 15-year-old daughter, was offered an opportunity to attend a seminar at Harvard. She was in middle management in a bank, and it was very important that she go to this seminar, but you do not leave a fifteen-year-old girl alone in New York in an apartment for eight weeks.

A few days later, I spoke with a woman in a very important government position, who had a small infant. The nurse that she had hired, who was from Seattle, had taken one look at New York and gone right back to Seattle. So this woman was home interviewing nurses when an important vote was due down in Washington. I said to her, "What about your husband?" There was a dead silence, because the idea that it was not her job to find the caregiver had not crossed her mind.

It seemed to me that there never was a time when a central organization dealing with child care for working families was more needed. Women had flooded into the labor force, and neither the private sector nor government had responded adequately to the enormous changes that had taken place in our society. It was evident that other countries had moved much more rapidly than the United States in providing the services that families needed.

It also occurred to me that the major women's organizations had not assumed much leadership on behalf of the masses of women in our country who are working full time and struggling to find child care. I called some of the leaders of these women's organizations and asked them if they would meet with me. At the same time, I invited the editors-in-chief of several women's magazines. During the course of our meeting, I said to them, "You deserved to lose the Equal Rights Amendment. Apparently you haven't been watching what's been happening to women in our country. There have been dramatic changes, and somehow you are not representing your constituencies." They responded that they were aware that there was a major problem, and they suggested that I help them to become involved. I responded, "Certainly not." I've been working with them ever since.

At a second meeting, we invited representatives of the major national child care agencies and other child care experts to join us. Almost immediately we became aware of the importance of "turf." It appeared to most of us on the outside that the child care leadership had formed a tight little group but that there was a great deal of mutual suspicion.

Since the early meetings, civic, corporate, and government leaders

have been added to the board of what became the Child Care Action Campaign. Our mission quite simply is to increase the quantity of child care in this country, improve its quality and its affordability, and develop a vision or plan that would describe what services should look like in the future. Existing services do not meet the need, nor are they linked together. The child care field is fragmented, and that fragmentation adds to the difficulty parents have in finding care.

Women's advocacy organizations had not been interested, nor have they become really involved since. They have failed to see the importance of the connection between opportunity for women and women's ability to find child care.

First, it was important to alert the country to the fact that there was a desperate need for affordable, quality child care. As a result of our work with the media, there was a magazine blitz in February 1984 that brought in an enormous influx of letters: on one day alone we received 5,000 letters. The stories that people told us were sometimes funny, and often heartbreaking — more often heartbreaking.

The letters gave us a picture of enormous need and of many different kinds of solutions. They also showed fragmentation and resultant chaos in the child care field. One of our objectives at Child Care Action Campaign is the establishment of a continuum of services, by which we mean an ongoing system that parents can use from the time a child is an infant, moving the child from one program to another as the child grows up, so that the parents will not have to seek new services every other year.

The Insurance Crisis

Since Child Care Action Campaign is committed to increasing the quantity and improving the quality of child care, we were alarmed when the liability insurance crisis occurred in May of 1985. We began to get phone calls from all over the country, with reports of insurance cancellations or of astronomical increases in the cost of premiums. We realized that if child care centers and day care homes could not obtain insurance, many of them would have to close.

We organized a committee of representatives of child care agencies to meet with representatives of major insurance companies. We realized that we would have to convince the insurance companies that child care is not a high-risk industry. It was obvious, however, that wide diversity of licensing and regulation laws, and the differences in

inspection and monitoring from state to state, constituted a problem. In our first meeting with the insurance companies, we were asked, "What is day care? We really don't know what we have been insuring in the past. Before we can offer insurance at a reasonable rate, we should begin to understand your industry."

We have a job to do, and that is to sell the insurance companies on child care as a responsible industry. That is precisely what we have been trying to do for the whole country, yet we have been doing this without defining the product or learning the processes of marketing.

Changing the Image of Child Care

In the first place, we have a product with a lot of different parts. We didn't even know what to call it. The words *day care* imply a program that operates only during the day, but mothers are working on swing shifts and at night, and some of the care that we must provide in the future will take place at odd hours. *Child care* in the mind of the public covers adoption, foster care, and other kinds of programs. It may seem like a small thing, but at some point it is going to be imperative for us to find the right word to describe the substitute care that is necessary, in varying degrees, for all families.

Second, public relations experts tell us that if you want to sell a product, it must have a good image. Our image was good in some respects and not so good in others. Head Start has had good press, and a recent study that was well publicized indicates that children who have had preschool education are likely to have better records in school and are more liable to attend college. But lately there have been a number of reasons why, according to the insurance companies, we have been labeled a high-risk industry:

1. A well-publicized conference on prevention of infectious diseases left many people with questions about whether group care was dangerous for young children.
2. Sexual abuse has become a front-page headline. We will need the help of everyone in the field to provide the media with positive material in order to counteract this very negative image.
3. The field does not inspire much respect. The salaries of child care providers reflect that. In a country where money is so often

the measure of a person's value, the extraordinarily low salaries of child care providers make our product harder to sell.

4. Child care has for many years been considered a welfare, or poverty, program. Obviously it is important to subsidize those who cannot afford to pay for child care, but child care today is needed by families at all income levels. One of the reasons why the Social Security program has so much support is that it is available to everyone.

President Nixon once called day care a "Communist program." Although I was outraged at the time, in retrospect he was quite right. Russia was doing a fantastic job of preparing their children to live in a Communist world. We on the other hand were sitting here ignoring the opportunity to prepare our children to live in a democratic society. Perhaps the approach of highlighting the long-range effects of child care, or the lack of such care, is a better way of selling our product than talking about need.

Marketing Child Care

If we are going to change attitudes, we must deal with policy makers and opinion formers. There are a number of different levels of policy making in the country. Government is perhaps the most important, but corporate leaders are also policy makers. The chief executive officers of corporations, however, are generally elderly white males, close to retirement and usually unaware of the concerns of the average working woman. In the corporate world, we need to address the younger men whom we can identify as future leaders.

Obviously, the media shape policy. Television continues to play a major role in shaping public opinion. We should be thinking of ways to bring life and action to our stories so that they are suitable for television. Newspapers, periodicals, printed matter of all kinds can help not only in shaping policies but in disseminating information. Child care advocates need to learn how to use the print media and how to create news. Child Care Action Campaign is developing a media kit, in order to help local organizations do a better job of selling.

The most important place to start working on public support is in the halls of government. Elected officials respond to their constituencies. If there is no visible or audible support for child care in a community, the chances are that members of Congress will not put the

same vigor and force behind a child care bill that they would if they received a clear message from their own constituencies.

We are recommending that child care organizations and providers become involved in political campaigns. There is nothing wrong with working in campaigns — but it is essential to pick the successful candidate. Elected officials look to the people who supported their campaigns, and if child care advocates are among those who have given support, successful candidates are likely to remember. The elderly learned this a long time ago. Senior citizens are extremely active in the political process today, and that has paid off.

For child care providers, marketing has too often been an ingrown process, and child care experts, providers, and advocates have been going to conferences and seminars and meetings of all types, giving erudite papers to each other. Child care, or the lack of it, affects the whole country. Everyone is a stakeholder. Involving public leaders in programs, inviting them to serve on boards, and asking them to speak at conferences is essential.

There are many groups that can be sold and that can help with the selling. Senior citizens working in child care programs are not only an asset to the program itself but a voice in the community. They can be forceful advocates.

Civic and fraternal organizations should be involved. Certainly pediatricians have reason to care. They can help educate parents on what to look for in placing their children. They can become far more active in assuring that child care programs meet health standards.

To summarize: First of all, we must know what we want. We must know what a child care system should be and begin to do some of the long-range planning that will eliminate fragmentation. What should child care look like in this country? Who should be doing what? Should government be the central source of information, since with their computer systems and regional offices they have the capacity for this? What institution should subsidize those who cannot pay for care? Exactly what kind of subsidies do we want?

We must learn from business, from industry, and from the public relations experts how to develop a positive image. We must send the media our story, and we must invite the public to join the child care providers and advocates in interpreting the words *quality*, *affordability*, and *cost*. We must get their help in developing decent wage scales for providers.

Sitting here at this conference, we have been talking as professionals and using the term *professional*. We have talked very little about how precious children are. Some countries apparently have more feeling

about this. In America, we tend to talk about problems and need. We seem to be reluctant to talk about the charm and the precious quality of children. We are even a little uncomfortable with our roles in the child care field. I tend to apologize for the fact that I'm working in child care. Is that because I am aware that, as a whole, our country does not really value its children? I hope, as we move forward trying to seek child care under whatever name we eventually invent, that we talk frequently about how much children mean to our future and to us all today.

DISCUSSION

Ellen Galinsky: I know that it is easier to sell things if you narrow them. On the other hand, we've had a great deal of success with corporations, unions, and other constituent organizations by broadening the issue and calling it *work and family life* instead of *child care*. We never start with the issue of children but with the effects of work on family and of family on work, so that we look at time, scheduling, job control, vacation, and so forth, and then get on to dependent care, which is care for both children and older people. By then we have everyone realizing that this is an issue that affects them.

Elinor Guggenheimer: I think involvement is the key. You make people feel that they really have personal involvement in a program. Perhaps through your method we may eventually get a maternity leave policy in this country, or family leave policy.

Ellen Galinsky: One of the problems is that we have become divided in a territorial issue. The child care people need to work together with the maternity leave people and others.

Elinor Guggenheimer: I agree.

Rebecca Fewell: Susanne mentioned tying in the need for support for the aging population. I wondered if you are aware of agencies considering linkages between grandparents and children. Grandparents have a great deal of interest in their grandchildren. Perhaps we could market our product in one section of the country, as they do in the business world. Florida would be a place where we might get some money for support of a program that would link those two and serve them as a unit.

Elinor Guggenheimer: We have an intergenerational program that we are trying to have funded. We want to set up teams in the senior nutrition program centers and train them to be teachers' aides.

Susanne Martinez: There are some older American volunteer programs, through the action agencies. The Elvira Lewis Foundation in California has a model of intergenerational child care programs, and they have been using a foster-grandparent type of arrangement.

Elinor Guggenheimer: I've heard about that. The problem for us is that we have put a stipend in; we would like it not to be purely volunteer.

Susanne Martinez: It's one way to help low-income seniors who want to work part-time and have some involvement.

Rebecca Fewell: I'd like to see a media blitz with the two generations together: grandparents and grandchildren on television pleading for the support of child care. We have done a lot of work with grandparents of handicapped children. Grandparents who live in Seattle will be deeply concerned about their handicapped grandchildren in another state and want to know how they can support them when they can't be there in person. We are able to share with them ways to do that.

Betty Caldwell: One of the complications with grandparents has to do with the family breakups that we have now. Many grandparents feel totally cut off from their grandchildren by custody decisions, and that probably decreases their role as advocates.

Susan Aronson: With the insurance crisis that the child care programs have recently experienced, I think we have an opportunity to ask that the insurance industry both protect itself and do a job for child care by identifying the significant risks that should be prevented in child care environments and by monitoring those risks.

Elinor Guggenheimer: Yes, we now believe that some of the requirements the insurance companies make will in fact provide a better level of protection for children. We are not going to let the insurance companies decide what child care should look like, but they are going to require health and safety measures.

Susan Aronson: One of the principal fire safety standards affecting child care is child/staff ratio. You have to have enough adults to evacuate the children you have in care. It turns out that when you look

at just the pure pound weight of infants that an adult can get out by whatever means, it is very close to the child/staff ratio that we would want for child development reasons. How many twenty-pound nine-month-olds can one adult manage to carry? If you have four of them, you've got eighty pounds. Those minimal standards for fire safety may very well have a strong impact on child care quality standards.

Susanne Martinez: I totally agree with the remarks you made about building constituencies and the political process. People have to be made aware of the importance of advocacy. The opponents of child care are very active. When they disapprove of something, they immediately grab pen and paper and let you know. But although we know from polling data that child care is the number one issue for vast numbers of people in California, we get relatively few letters of support. You have to let policy makers know when you approve of something.

Betty Caldwell: That has been borne out time after time when these bills come up for passage. All the active members of Congress say that the stacks are 100 to 1, and in spite of all that we can mobilize, we never match the sheer quantity of communication.

I'd like to make a comment in support of what Ellen said. I think one of the mistakes we have made in marketing child care is to tie it too closely to women's issues. It is a total family and total societal issue. In our marketing, anything we can do to stress that this is a family situation, that these are needs that families have, however a family is constituted, will help generate public support.

Judith Palfrey: When you do feel apologetic, is some of that because what we are talking about is a necessary evil in our minds, because we think that there is an ideal situation that we've come away from? I think there is this underlying sense that we are arguing at some level with a necessary evil and asking in what ways the standards can be raised so that it's no longer that. We have created a system which honors and values children as central. Sue helped me a little bit earlier by saying that there are ways that the child needs to fit into the total system and needs to understand some of the necessary evils. But I think that we are always a little apologetic, because we haven't yet got to a balance.

Ellen Galinsky: If you work just on child care, I think you can feel that. But if you work on improving employment policies as well as on improving the system, then I don't think you need feel any sense of apology for a necessary evil.

Sandra Scarr: I think it goes even deeper in our culture, that we feel the child in day care is being deprived of something that he or she would have had if Mom were home full-time, and I think that's what we need to examine. I wasn't kidding yesterday when I said that we will reach a new height when we can begin to talk about children who are in child care or deprived of child care. What's wrong with having a relationship with more than one person? Isn't it good for babies and young children to get to know other people? Unless we feel that basically it is a good and acceptable way of rearing children, then I think we will always be apologetic.

CORPORATE SUPPORT FOR THE CHILD CARE NEEDS OF WORKING PARENTS

Dana E. Friedman, Ed.D.

Parenting today is like solving a Rubik's Cube: solving one problem often creates another. For instance, having a job that helps support the family means that child care arrangements must be made. Then something happens — the child reaches a new level of development, the work shift changes, the in-home provider is taking a vacation, school is out, the child is sick, or the parent has to work overtime — and new arrangements must be made.

This balancing act is a daily concern for the majority of today's working parents. The task requires skill and flexibility and a tremendous amount of luck, for parents are often caught between corporate policies and those of a child care program. These external forces may be more important than parents' own fortitude and resourcefulness in determining whether they will be able to sustain their work and child care arrangements.

This paper is about the ways in which employers and child care providers can support — or undermine — a parent's ability to make

satisfactory child care arrangements. Described first are various ways in which more than 2,500 employers currently provide child care assistance, including on-site day care centers, flexible benefits, and counseling programs. Also explored are elements of the corporate culture, such as scheduling and flexibility, that may have a subtle but profound effect on parenting. Finally, the paper examines some of the secondary effects and unanticipated consequences of the corporate response to working parents.

Why Are Employers Involved in Child Care?

On November 24, 1981, on the front page of the *Wall Street Journal*, the U.S. Chamber of Commerce predicted that child care would be the fastest growing benefit of the 1980s. In 1985, the Employee Benefits Research Institute called child care *the* benefit of the 1990s. The expectations are borne out by the experiences of nearly 2,500 employers now providing some form of child care assistance, more than quadruple the number identified in 1982.

An increasing number of companies are realizing that if they ignore the family needs of their workers, they will be ignoring the predominant concerns of a growing portion of their work force. To the degree that companies lose touch with the needs and expectations of their workers, they lose their ability to attract and retain a productive work force. They are beginning to realize that their benefit plans, designed in the 1940s for the male breadwinner, are no longer appropriate and may even be counterproductive. Approximately two-thirds of the workers that will be recruited into the labor force by 1990 will be women, and their needs are likely to play a significant role in the design of recruitment efforts, productivity incentives, and benefit plans.

Most companies offering child care support are in high growth industries that need to recruit labor in short supply. Others are concerned about retaining the labor force they worked hard to recruit. The potential for reducing turnover, absenteeism, and tardiness is also attractive to employers concerned about competing in today's world markets. Child care may also be seen as a way to reduce stress or improve the quality of work life so that workers are more productive.

The younger company president whose wife works and whose child is in day care is more likely to be receptive to company-sponsored child care than the older executive who has never experienced the

strain of balancing home and work life. Family-owned businesses may be more interested in child care issues because family values are often incorporated into corporate policy. And companies that produce family-related services or products are more likely to be receptive to child care solutions in order to demonstrate concern for family-oriented consumers.

The form in which the company responds to the child care needs of employees depends on a unique blend of management agendas, parent needs, and community resources. Since managers ultimately make the decisions, it is their agendas and expectations that must be satisfied, but corporate self-interest can be satisfied only if parents' needs are met. While some parents need services, others may need assistance in finding or paying for them, and others may need a more flexible work schedule.

Meeting Employees' Need for Services

On-site child care centers. The majority of employers do not find on-site centers appropriate or affordable. Companies in large cities find the cost of downtown office space prohibitive, and parents prefer care closer to home to avoid commuting in rush hour on public transportation with young children. For other companies on-site care is impractical because it limits the number of parents who can use the center by virtue of its size, the ages of the children accepted, or the particular curriculum chosen.

Those employers — an estimated 150 companies and 400 hospitals (Friedman, 1986) — who have sponsored on-site centers, however, report high satisfaction with them. The nearby presence of children tends to humanize the workplace, and the center projects a positive image in the community. Parents are gratified to have the commuting time with their children and the opportunity to breast feed or share lunch with them.

Family day care. Family day care allows more flexibility for employers because: (1) it can be located geographically close to either home or work; (2) its hours can be extended to accommodate shift work; (3) it can serve a range of ages, so that parents need make only one arrangement; and (4) it can expand or contract as need changes among the employee population. Several companies have contracted

with local community-based agencies to recruit, train, and monitor family day care providers along the employees' commute.

Consortium arrangements. Employers can share the costs, risks, and benefits of establishing and operating a child care center as a consortium. This is a particularly advantageous arrangement for small companies that may not be able to afford such an endeavor alone or for those in downtown locations, industrial parks, and shopping malls.

After-school care. The three-o'clock syndrome is when productivity plummets and phone usage soars. Companies have begun to support before- and after-school programs run by school districts and other community groups, providing the extra funds needed to hire new staff and equipment. Other employers support "warm lines" — nurturing hotlines — for children to contact when they get home from school. Some companies create summer day camps for employees' children on nearby company land or community property.

Sick-child care services. Employers see the negative effects of child care problems most directly when children become sick and parents stay home to care for them. Several companies have created infirmaries attached to child care centers, and others contract with in-home nursing services to send trained nurses into the child's home.

Meeting Employees' Need for Information

Information and referral services. The child care system is complex — often fragmented, poorly advertised, and varied in quality. A poor choice by the parent may require additional days off from work to make new child care arrangements. Several companies have created in-house information and referral systems, and at least 500 companies have contracted with existing services to help their employees locate available and appropriate child care.

Parents may find other opportunities to deal with child-rearing issues within employee counseling programs or parent education seminars offered by their employers.

Meeting Employees' Need for Financial Assistance

The majority of employers providing child care do so by helping their employees pay for needed services, in one of several ways:

Discounts. Approximately 300 employers have negotiated reduced rates for their employees at local child care centers. Most programs offer a 10 percent discount to the employees, and in about half the contracts the employer contributes 10 percent of the fees so that employees benefit from a 20 percent reduction in their child care costs.

Vouchers. In a voucher program, the employer subsidizes a portion of the employee's child care costs incurred at a program selected by the parent. The company may put the money into the employee's paycheck or pay the provider directly. Only about 25 companies offer vouchers, because of their potential cost and the existence of a less expensive alternative: flexible benefits.

Flexible benefits. Flexible benefits allow employees to choose, from a menu of taxable and nontaxable benefits, those that suit their individual needs. The 1981 Economic Recovery Tax Act made child care a nontaxable benefit and a convenient option to include in flexible benefit plans. These Dependent Care Assistance Plans, as they are known, solve two problems in employer provision of child care: cost and equity. Since they are funded through salary reduction, the employee receives pretax dollars to spend on their child care at a cost to the federal treasury, not to the company. These plans also resolve the fear that if child care were offered, nonparents would demand a benefit of equal value. Flexible benefits can satisfy a range of needs. An estimated 1,000 employers provide flexible spending accounts that include the dependent care option, which may be used for child care, care of elderly parents, or care of handicapped dependents.

Meeting Employees' Need for Time

More than one-third of all employees experience stress that is due to the time demands created by their work and family responsibilities (Pleck, Staines, & Lang, 1980). Alternative work schedules such as flextime, part-time work, job sharing, and work-at-home have been

found to help employees work more productively at home and at work.

Leave policies have also been revised to accommodate working parents. Approximately 29 percent of the Fortune 1300 companies offer sick-child care leave (Catalyst, 1981). Only 40 percent of women are currently covered under pregnancy disability. Most women employees return after the allowed six to eight weeks of paid maternity leave. Among higher income women, 68 percent return within four months. These women do not necessarily want more time off but rather a transitional return to work on a part-time basis (Catalyst, in press). Paternity leave is being offered more frequently, but preliminary reports indicate that most men take only a few days off around the time of childbirth.

Implications for Parents

Employer involvement in child care is based on its ability to solve other management problems: to reduce absenteeism, turnover, and tardiness or to improve productivity, morale, and recruitment. If child care services can reduce absenteeism, the implication is that working parents require more services than others in order to be as productive as others, and therefore that they are more expensive to hire. Some contend that this special treatment may lead to discrimination.

A related concern pits child care advocacy against two decades of civil rights achievements in the work world. Companies have been forced to ignore the race, gender, age, and even sexual preference of employees. Civil rights laws condemn special treatment, yet child care programs require companies to provide special treatment to employees with young children.

Furthermore, assertions that child care provisions can solve a range of management problems may mask the importance of other work conditions. The children of employees who are underpaid, overworked, or in unhealthy environments may benefit more from other changes in work policies than from provision of child care benefits.

Implications for the Child Care Community

If nothing else, corporate scrutiny of the child care system has revealed major gaps in the services. Companies have learned more

about the adequacy of the system than most policy planners in the public sector.

Corporate support for information and referral services often leads to a more sophisticated child care system that permits greater efficiency in matching the supply of and demand for services. The improved system benefits not only employees but other community residents as well. In order to fulfill company contracts, information and referral agencies are finding that they must devise linkages to serve employees living in different communities. The geographic boundaries around which they were originally designed may not conform to the needs of a diverse employee population.

Support of these services also raises the question of the ability of the child care system to satisfy parents. Company contracts with referral agencies also include providing parents with seminars and brochures about how to recognize quality in the programs they visit. This education may create expectations that the system cannot fulfill.

Corporate financing through benefit programs may lead to a general improvement in quality, however. Parents' increased purchasing power may enable them to choose better quality or more satisfactory care arrangements. Services will begin to compete for the children of parents who have access to this employer assistance, and the increased competition may lead to improved quality of care.

What may have an even more dramatic effect on child care than direct corporate assistance for it are the internal policies that companies develop to respond to working parents. Flextime will require that child care programs adapt to new schedules, and part-time options such as job sharing and work-at-home will raise similar questions about how child care programs will charge fees or organize a curriculum and staffing pattern for children attending part-time.

Implications for Government

Government has been encouraging greater private sector support for social services. But corporations cannot be expected to meet the needs not only of their own employees but of parents in job training and in companies that are too small to provide new benefits and services. Approximately 50 percent of American workers are in companies with fewer than 100 employees. Whose responsibility is it to help these parents with their child care needs?

If there were a stronger federal and state commitment to creating an

adequate system of child care for working parents, then government efforts to strengthen the field would ultimately facilitate employer involvement. Employers generally want to buy into the existing system of child care. If the system is limited, so are the opportunities for company participation.

The inequities of various corporate alternatives have significant implications for public policy. Most company initiatives seem to address the needs of middle-class parents, who face continual struggles but who are better off than more vulnerable populations who have fallen through the "social safety net." Salary reduction in flexible benefits programs is of greater benefit to middle- and upper-income parents, and the federal government is paying for it. Lower-income employees may benefit more from the child care tax credit, which also provides limited financial relief.

Implications for Society

Every week, at least one new child care initiative by a company is made public. Along with enthusiasm about growth should come a consideration of the long-range consequences of that initiative and the degree to which it is really serving the best interests of children and families. For instance, sick-child care services facilitate the ability of parents to leave their young children when they are ill. Is that our true objective? While the alternatives are few, perhaps the advocacy of more liberal leave policies would do more for children and parents.

A similar concern is raised by voucher programs that pay for a portion of child care expenses only during the child's first year of life. That provision demonstrates a form of family allowance. In most of Europe, family allowances were developed for the purpose of keeping parent and child together. Are we moving toward a system that keeps them apart? What is it we are saying about the importance of family life in America with some of the more "innovative" employer-supported child care initiatives?

Conclusions

The pattern of employer support for child care, and the reasons for the lack of it, raise questions about society's commitment to and

support for parenting. To encourage institutions to support working parents and to consider the effects of that support, we need to create an environment at work where parents can express their concerns. The traditional work environment keeps work and family life separate, and employees do not feel safe in voicing their family concerns. The change in the composition of the work force requires a more deliberate effort to solicit the views of working parents. Employee attitude surveys, needs assessments, quality circles, employee counseling programs, information and referral services, and parent education seminars — these can meet an immediate need of parents while helping employers to understand the nature of the problem and the need for well-balanced solutions.

PART III
PROFESSIONAL DIVERSITY
IN CHILD CARE PROGRAMS

APPROACHES TO THE STRUCTURE OF CHILD CARE: PROS AND CONS

Sandra Scarr, Ph.D.

Assumptions about the needs of babies and young children control our assumptions about what parents, especially mothers, ought to do. If we assume that infants need detailed training and infinitely sensitive, responsive care to grow up to be normal adults, the tasks of parenthood are correspondingly delicate and consuming. If we assume that infants are biologically programmed to develop in their own ways and need only loving support to become themselves, the tasks of parenthood are considerably less consuming and onerous. This paper discusses contrasting expert opinions about the nature of children and the duties of parents and the implications of those opinions for child care by caregivers other than mothers.

Parents feel considerable guilt over leaving their young children in the care of others, even when the necessity to work leaves them no other choice. Research shows no evidence, however, that high quality

extra-familial care has ill effects on children. On the contrary, there is evidence to show that such care can be beneficial. This paper defines high quality care and describes what parents should look for in making child care arrangements for their young children.

Two Views of Children's Needs

There is a great diversity of opinion among experts about what children are like and what they need. I like to illustrate this diversity by contrasting the views of two child-development experts in this century.

Arnold Gesell, on the one hand, portrays the child as a robust, healthy, biologically organized developer who with a little support from his parents will probably develop into a normal healthy adult. That view is held by the majority of the developmental psychology community at the moment. A healthy environment is important, but children are individuals, and they develop along their own developmental trajectories. They are not so fragile as the second view would have them.

This second view is best represented in this century by John Watson, who was extremely influential with parents. In his view, parents can make their child into whatever they want him or her to be. Watson's model of the child was very influenced by every detail of its upbringing and therefore needed detailed training from the parents. The parents' role was so demanding that Watson actually dedicated his child-rearing book in 1929 to the first mother who could rear a perfect child. He decided that parenthood was essentially an impossible task.

The Watsonian view has its present-day adherents among the baby-trainers, who feel that parents have got to be there every minute or the child will never grow up to be a competent child and adult. But there really isn't any evidence that children need that kind of constant attention from their parents. Children who have grown up in competent families, whether their parents work or not, tend to be competent children. Of course, the kind of care they have when they are not with their working parents makes a temporary difference. We certainly want to support high quality child care and ensure against abuse and neglect. But in fact it has not even been demonstrated that children do not recover from bad episodes. The evidence from studies such as Kagan and Klein's (1973) in Guatemala is that infants who are quite badly neglected in infancy look fine by the time they are toddlers, much like children in other societies. And while I am not advocating

this, the evidence from the kibbutzim in Israel is that infants who are cared for in groups of six and eight grow up to be perfectly normal children, adolescents, and adults (Beit-Hallahmi & Rabin, 1977).

We need to look at the consequences of balancing the interests of all the family members and how the family and work systems can function together. Our dilemma is in part in our views about what children need. We cannot afford today to take the view that a child needs constant family-member input in order to develop into a normal, competent person. And we are probably not going to be as relaxed as Gesell might lead us to think we can be. Somewhere in the middle there is room for us to make some judgments without creating harmful environments for children.

Styles of Child-Rearing: The Research

Most people who are alarmed at the increased use of group care are particularly concerned about the infants and toddlers. It's clear that in the first few years of life children need a great deal of individual attention from adults with whom they have a loving relationship. I make *adults* plural on purpose. For many years we pushed the view that the mother was the only important person. As women have gone back to work, of course, these views have been modified. For one thing, we have rediscovered fathers as parents. Recent studies of aspects of fathers' participation in the family (Radin, 1982; Russell, 1982; Sagi, 1982) show not only that fathers may play a special role in being fun, in being playful characters, but that fathers can also take primary care of their children without the children being emotional disasters.

We are also seeing a lot of studies on alternate family forms. We used to have studies about the disasters of single parenthood — how awful it was for a child to be reared in a single-parent family. In fact, we still have studies being done from that set of assumptions (e.g., Rutter, 1982). But we are beginning to see studies that ask questions like "How do single parents cope? What are the strengths that they can bring to the family? What kind of support system do they need?" (e.g., Eiduson et al., 1982). Rather than just asking what's wrong with the children who grow up in these various family forms, the newer research looks at what the extended family has or does not have to offer. Cultural differences become important here.

What are the problems of divorce? Is it all a disaster? It turns out, if

you look closely at Michael Rutter's studies (1982), for example, that what's more disastrous to children is the continuing conflict between parents, in which the child is living under daily tension. Rutter found in several of his studies that some children of divorced parents are better off than children who are in intact families but are under tremendous strain and family conflict.

We need research that asks more refined questions about what it is that makes for a good rearing environment for children and what the serious problems are that we ought to be worried about. We need to ask questions that refine our views about the range of possible alternatives that are healthy environments. There isn't one answer for every child or every family.

Specifically, we need to ask where we start getting in trouble. Isn't it possible to have perfectly healthy children in a single-parent family if the parent is functioning well? We have certainly seen, in the research on employed mothers and on the effects of working mothers on their children, that there is no single answer to that question precisely because the question is not formulated in such a way as to be answerable. The National Academy of Science report (Kamerman & Hayes, 1982) is very clear about that. The study found no consistent pattern of results that suggested any blanket relationship between maternal employment and children's outcomes regardless of the ages of the children at the time of the study.

Why should we think there would be a singular relationship, if there really is a range of possible environments in which children can grow up to be healthy? The patterns of family life can vary. We are finding that children who are in reasonably supportive environments — who have relationships with some adults in their environment on a consistent basis and have reasonably safe, healthful, developmentally appropriate care — grow up to be fine. The research literature on families can be reassuring in telling us that we have some options that we might need to use, even if we don't think they are ideal.

Throughout this century, we have told mothers, particularly through the research on bonding and attachment, that they play a special role in their children's lives. I think we have used that to make mothers feel very guilty and anxious. Many mothers feel an overwhelming sense of guilt in going back to work after the birth of a child. They assume that the child would be better off with them full-time than with them part-time and with another caregiver, also part-time. I think this assumption is lingering in most of our heads.

In fact, there is some evidence that children with more than one attachment — to fathers, to caregivers, to someone else beyond a

solitary mother — are actually more secure and better adapted to their future lives (Schaffer, 1977). Even if they don't go to school until they are four, children eventually have to move out, get to know other people, trust other people. Infants who have attachments to more than one person are more secure in the face of inevitable separations from the mother. They are better adapted and socially more competent. Babies not only do not need exclusive relationships with one mother but can have important relationships with several people. Why should we feel that we are cheating our infants by taking them out to get to know another kindly, loving caregiver?

I certainly can argue that it is better for children to be in part-time care with a healthy, well-adjusted baby-sitter or caregiver than to be with a depressed mother at home. One thing we know from studies (e.g., Crosby, 1982) is that women who are not in the workforce but wish they could be constitute the most depressed group in our population. They are providing very depressing care for their infants.

There are also mothers who consider that they are better mothers when they are not full-time mothers. The relationship they have with their children before work and when they come home from work and on weekends is much higher quality than it would be if they were home all day. I think we can build a case that in fact, both for parents and for children, being together constantly may not be the best arrangement, that children benefit from relationships with others and that parents benefit from having a more varied life and contact with adults. We have to think about this not just as selfishness on the part of parents. It is important to their own ability to contribute to the relationship with their children, their spouses, and their families in general.

Instead of being on the defensive about whether child care of good quality can be damaging to children, I think we need to go on the offensive and say, "Look, there are good reasons to suspect that these are healthy arrangements for children."

Quality Child Care

Whether the caregiver is a full-time mother or not, the care must be good quality care. Quality child care is first of all developmentally appropriate. The younger the child, the more individual adult attention that child needs, until the child benefits from being around peers. During these very early years, the most appropriate form of extra-

family child care may be either family day care or that provided by a trained person who comes into the child's own home. When children get to be three to four, they clearly benefit from peer association. From about age three on, the most effective type of child care is probably in a child care center, where there is more sophisticated equipment and where the caregivers are probably better trained than they are in family day care or home care. In making a selection, however, it is important to take into account the individual child. Children who are a bit slow to mature or relatively shy may be better off having another six months to a year in family day care.

Sitters in the home present a special problem. Screening of such people is often done intuitively with the help of references, as they typically have had little training in child care to point to in a résumé. There is no monitoring of what goes on in one's home during the day when a sitter is there. In family day care, where more than one parent is coming in and out, there is at least some control over what goes on, and parents have the opinions and experiences of other parents to go on. In most child care centers, there is scrutiny not only by other staff members but again by parents coming in and out at different times of the day and observing what is going on.

In considering child care centers, parents need to look at the relative degrees of openness and structure in the programs they are considering. Some are highly structured. The day is carefully scheduled, and the child in effect is marched through a series of planned activities, with very little individual choice about how he or she wants to spend the day. Children under those circumstances may not be able to pursue the things they are interested in, but they are exposed to a great many different kinds of developmentally appropriate opportunities.

At the other extreme is the unstructured — which can get to be chaotic — situation, where virtually nothing is planned. The day is very casual. Children never seem to be engaged in anything. Three- and four-year-olds in those circumstances often get into arguments and mischief with other children.

Between those two extremes there are obviously all sorts of arrangements. Parents need to evaluate their own child-rearing philosophies and ask themselves what they think is good for children at this age. Relatively greater structure or openness isn't going to harm the child. What is important is whether or not the child-rearing that the parents provide at home matches that of the child care environment in which they are putting their child. Children can adapt from one situation to another, but it's easier for them if a consistent child-rearing philosophy is reflected at home and in the child care situation.

The most important thing parents can do in evaluating child care is to go in and observe and to know what they are looking for. In terms of physical care, does the setting provide timely and pleasant meals and snacks? For babies under two, this means do the adults hold the babies and feed them bottles when the baby is hungry? Do they feed regularly scheduled meals to those on solid foods? Do they talk to babies as they feed them? For preschool children it means good nutrition, regularly scheduled meals and snacks, and a pleasant atmosphere.

Does the setting provide adequate rest and naps? Is there a good place for naps and rest? Is nap time rigidly scheduled or flexible?

Are the children kept reasonably clean? Children should be encouraged for reasons of hygiene and general cleanliness to have a regular schedule of washing hands and, if they are there all day, of brushing their teeth. An overzealous concern for neatness and cleanliness among preschool children is not necessary. There are times when it's healthy for them to get dirty, as long as they get cleaned up before they eat and go home.

Does the setting provide enough toys, books, games, and opportunities for varied play under safe circumstances? Is there adequate supervision for the use of potentially dangerous items, such as saws, hammers, and the like? Are there special toys for babies which provide experiences with shapes, textures, and sizes? Is there adequate supervision during play to ensure the children's safety?

Does the space available for the children allow for both harmonious group activities and for individual choices of how to spend time and places to do it? Children in child care centers can be overwhelmed by the constant social contact with other children. Can they have quiet times when they can sit in a corner on a pillow with a book, when they can talk with just one other child or perhaps ignore everybody for a while? Is the space attractively decorated and arranged from a child's eye perspective?

Do the caregivers know enough about child development to provide good care? Parents can ask caregivers about their training and experience and also talk with them to check out the areas of agreement and disagreement between what the parents believe is important and what the caregivers believe is important.

Do caregivers supervise babies and children closely but not intrusively? Children need to be socialized in child care. They have to be supervised carefully and closely, not only for safety reasons but also because they can't be allowed to get away with constant bad behavior that violates the rights of others. Child care centers typically are more

concerned with the gross management of the group than with the fine details of "who kicked who first." They don't tend to intervene as much as a mother would at home. And it is not helpful if caregivers simply order settlements. Children have to learn to negotiate with each other.

Do the caregivers use every opportunity to talk with babies and preschoolers? Adult/child verbal interaction is extremely important. *How* adults talk to children is also extremely important. We found in observations of child care centers of different quality that the children are best developed in those centers where adults are not issuing a lot of commands but rather are talking in affectionate terms and giving a lot of information to children (Ruopp & Travers, 1982).

Are there regular times in the day for music, reading, outdoor play, painting, free play, and time alone? Are there whole group times, small group times, and individual choice times?

Does the staff communicate with parents about their children's activities, development, problems, and special talents? Do the caregivers take time at the beginning of the day and at the end of the day to talk with parents? Do they offer parents the opportunity to come in for conferences? Does the staff have regular meetings with parents?

Does the staff ease the child's transition from home to care setting and back again? On arriving in the morning, the child should be greeted enthusiastically by the caregivers, even if he or she is not eager to be left at the center. In the afternoon the child should be bid goodbye with warmth and anticipation of the next day, whether or not the child is warm in return. Parents need to be confident that this is a good place, even if their child in the first couple of weeks is not all that happy about it, and they need a staff that is confident that it's all going to work out in the long run.

Do the babies and children in the center appear to be happy? Are they engaged in activities? Or are they wandering aimlessly, crying or fighting or looking bored?

Parents are not very confident consumers of child care. Some child care providers are really upset with parents, because as someone here said, when parents arrive at a new setting, their first questions are "How much does it cost?" "Can my kid get in here?" and "Can I drop him off tomorrow?" Good child care providers are frustrated because parents don't know what to look for. It's really up to us to make parents better informed consumers, to get the information out to them through magazines, newspapers, television, and through all the things that the NAEYC can do to reach child care personnel, so that they can participate in helping parents.

DISCUSSION

Elinor Guggenheimer: In New York, the increase in four-year-old care and kindergarten care to a longer day has pulled child care teachers out of centers. The benefits are better, the salaries are better. It has led mothers to put their children in there even though it is totally inadequate for the working mother. We need to take a look at what we are doing as we plunge ahead into increasing that preschool education. Because it's free, mothers will put their children in and try to make some half-baked arrangement for the time after three in the afternoon or during holidays or over summer vacations, driving out the community groups that have been filling these roles on a year-round basis and can't afford to operate any other way.

Regarding full-time parenting, we've been unable to discover any society in history where parents have ever spent anything like 24 hours with their children. Anybody who could afford it, in fact right down to the lower-middle class, had somebody in the home to take care of children, either a relative or a servant. And those who didn't have servants worked in the fields or in cottage industries or in Mom-and-Pop stores or did something else.

One last thing: you said parents could assess their own child and figure out what would be good. That would be marvelous if we had all those choices. But in many cases parents choose something that they themselves feel quite guilty about, and quite uncomfortable with, because it's the only thing available.

Sandra Scarr: That's right. I see things like that.

Ellen Galinsky: Although I agree that parents should be on the offensive about child care, I think that parents need to work through their guilt. That, by the way, is something that your book (Scarr, 1984) gives people a wonderful opportunity to do. I always recommend it to parents, because it helps explain what they're going through and why they have contradictory feelings.

I don't think that information alone will help parents through the anxiety stage. I really feel that it's a developmental stage of parents, because you find second- and third-time parents, even parents who are child care providers themselves, going through this period of asking "Is it normal, or isn't it normal?" We need to educate child care providers to understand the development of parents, so that when parents ask those three questions the caregivers will understand where in development that comes from and not feel unappreciated.

Third, as I read developmental psychology these days, I think that

parents have the influences not of just those two systems but of intermediate trends that are looking at how differential systems are responsive to differential influences at different times. That is, development is a combination of the parents molding the children and the children growing up on their own.

Finally, as I read Sheila Kamerman and Cheryl Hayes's research and the other research on the effect of maternal employment on children, it's not that employment had no effect, but that the way we were studying it, comparing groups of at-home mothers with groups of employed mothers, it didn't have an effect. I think that research has uncovered four areas in which there are effects on children. One is the mother's attitude and the family's attitude, whether the family thinks she should or shouldn't be working. Another is the kind of child care that is provided. The third is the stressful life events in the family, and the fourth is the job conditions, which researchers like Piotrkowski (1985) have been finding make an enormous difference.

Sandra Scarr: There are a lot of alleged interaction effects. For example, some would claim that if mothers have employment with which they're satisfied and the family approves of the mother's employment, then there are beneficial effects on children, but if the mother doesn't like working and the family thinks that it's really a shame she has to work, there can be negative effects. Remember, people are not randomly assigned to these positions. It's very difficult to make inferences about the causal importance of maternal employment from that kind of field study, because there are always alternate explanations. If you talk about the relative effects of maternal employment on boys and girls within the same family, Lois Hoffman has tried to say that maternal employment is something of a detriment for preschool boys, but not for school-age boys, and a benefit for girls of all ages.

Ellen Galinsky: High-school age is when the girls started to have problems, and school-age boys started to respond in achievement.

Sandra Scarr: And the girls were doing better than the daughters of unemployed or at-home mothers. Urie Bronfenbrenner is now saying that the issue of mothers' staying home with their infants is really much more an issue of what the mother has to give to the child. He's claiming that his more recent studies showed that if you have a mother who's not very smart and not very well educated, it's better for the child to be in child care. (Whereas, if you have a well-educated mother, she's probably providing a stimulating environment, and it might be

better if she stayed home, right?) I don't think the family issues are going to be decided on that basis, because I don't think that the pattern of results is very strong or very consistent. We would not be sitting here today advocating child care if every child went into an anaclitic depression because mother left to go to work. So obviously there are no results that look really bad, in general, from maternal employment.

Ellen Galinsky: Zigler and Gordon have written a paper in which they reviewed the Vaughn and Sroufe studies, looking at infant care (1982). They come out very strongly that the timing makes a difference in terms of when you put children into child care, looking at the anxious avoidant, particularly with boys. But all those families underwent other sorts of family stress. Seventy-five percent, I think, went through divorce or some other sort of family stress.

Sandra Scarr: Remember that the sample that Sroufe is talking about was picked as a particularly high-risk sample for child abuse. I don't think I'd want to generalize from this sample to most working-family situations.

Susan Aronson: I wanted to thank Dana and you, Sandy, for your presentations and to suggest that one way of linking the two of yours is that we need corporate and also public policy education about the values that working parents may teach to their children by working. I think it's a very wonderful thing when we allow parents to have other roles in their lives to model to their children, so that the children can develop those expectations for their own adulthood. It's time for us to teach corporate America that the future workers of America will learn to work by watching parents work, and it's time to teach public policy people that the future taxpayers of America will pay taxes if they learn that it's appropriate to work and to work well.

NURSING EDUCATION TO MEET CHILD CARE NEEDS

Juanita W. Fleming, R.N., Ph.D.

Changes in the health care delivery system are imminent. The not-for-profit community hospital is giving way to a health care industry characterized by multihospital systems, investor-owned institutions, and elaborate networks of outpatient services. The Diagnosis Related Groups (DRGs) and other fixed costs for health care seem to signal a move toward alternative forms of care that are more cost-effective than acute hospital base care. Prevention of health problems and incentives to stay well are likely to become more popular in our society.

These changes will to some extent shape the academic preparation of health care providers. One means of providing preventive health care services to young children and their families is through the group child care setting. The potential role for the nurse in the delivery of these services is a large one, and child care programs offer excellent learning opportunities for student nurses. This paper describes the contributions the nurse can make in the child care setting and the ways that nurse educators and students can be part of the interdisciplinary team that promotes the health and well-being of children and their families.

The focus of this paper is primarily on child care centers, but a large percentage of children under five are being cared for in family day care homes, with limited access to any health care resource at present. The community health nurse can play an important role in providing a linkage to health services for these children.

Child Care Programs as Settings for Nursing Education

Nurses who have received baccalaureate degrees from nursing programs accredited by the National League for Nursing have as part of their academic preparation courses in liberal arts and the physical, biological, and behavioral sciences. Content in management, nutrition,

community health, ethics, growth and development, transmission of knowledge, and culture also help provide the nurse with a broad educational background. Many students have an opportunity to choose electives. Nurses who complete these programs are exposed to all age groups in varying stages of wellness and illness who are being managed in both in-patient and out-patient settings. Some may gain additional experience working with children and families.

The use of child care programs as learning opportunities for student nurses is not new. Many educators view these programs as excellent settings for students not only to gain knowledge about human growth and development but to gain an understanding of the health needs of children served in child care programs. With the emphasis in nursing curricula on both wellness and illness, the use of these programs as clinical placement for student nurses is likely to continue to be extensive.

Nurse educators who are employed in major universities have the opportunity, as part of practice and service, to develop the role of health coordinator with child care facilities in their communities. The health coordinator serves as a role model for student nurses who are assigned to child care programs and works with them and with parents, staff, and children in the areas of health maintenance and promotion and illness prevention. Several child care facilities can combine their resources to hire a nurse coordinator to serve each facility on a part-time basis. The funds from the programs accrue to the university that supports the practice and service role.

The role of nurse educators and student nurses in the implementation of quality child care is a challenge and an opportunity. Group care operations for children vary in titles and services. Comprehensive group care operations often include a range of services and are designed to meet social, psychological, intellectual, and general health needs of children and their families. Blum (1983) has said:

Day care centers should contribute to the health of children. In an ideal world, they would ensure physical examination before enrollment for children; they would guarantee that all of their enrolled children had up-to-date, appropriate immunizations; they would be alert to warning signs of illness or handicaps; they would provide education and consultation to parents about nutrition, physical development, hygiene, and dental care; they would be able to provide nurturing, comfortable care for emergency illnesses (p. 67).

Emotional well-being can also be considered an essential part of health maintenance. The nurse thus has a number of roles to play in contributing to the health of children in child care settings.

Health Promotion

The primary role of nurses in child care facilities is to help promote and maintain health as well as to prevent illness. There are three distinct levels of prevention. *Primary prevention* is taking action to block exposure to something that would produce a health problem — for example, helping parents develop a parenting style that promotes a healthy and positive relationship between parent and child. *Secondary prevention* means both the early detection of an abnormality or deviation from normal and prompt intervention prior to clinical manifestation of a problem — for example, helping at-risk families with parenting skills. *Tertiary prevention* is taking action once a problem is evident and providing services to minimize the problem or prevent its recurrence — for example, helping a parent who has abused a child to gain parenting skills.

All children and their parents are vulnerable during the child's early years, the child because of rapid and complex development and the parents because they are under real and imagined pressure from society to guide their children's development (Rogers, 1980). Nursing intervention and support in child care facilities may be welcomed by parents. Rogers notes that realistic, informed, and self-critical medical support and intervention could be of great potential benefit to families during this period, especially because most parents are highly motivated to promote their children's health and therefore welcome good advisory facilities.

A key to health promotion is the development early in life of good health habits. The theory of the self-fulfilling prophecy, or Pygmalion effect, suggests that children will behave as expected. Nurses, parents, and caregivers not only can facilitate the normal growth and development of the children but also can help them develop a positive orientation toward health. The nurse can help parents and child care staff understand the importance of their expectations on the developing child.

Just as a healthful physical environment is crucial to the promotion of health in children and their families, so too is the psychological environment. People often feel and act according to how they see

themselves, and fostering good health habits enhances their attitudes about themselves. A key function of the nurse in child care settings is to help the children, their families, and the staff to have positive attitudes, beliefs, and perceptions about their own health. In order to do this the nurse will have to listen, observe, and understand their views about health and about how they seek health. It is important that the nurse and other staff members reinforce the behaviors that promote health.

Positive reinforcement of the behaviors that promote health may start with children with the use of *shaping*. Shaping consists of reinforcing approximations that the individual achieves toward the desired act: for example, praising children for running water over their hands after toileting. Praise in proportion is one of the easiest ways to reinforce behavior.

Modeling is also an effective means of learning. Social learning theorists believe that children learn essentially through imitating or modeling what they see others do. One of the areas in which modeling may be effective with parents is discipline.

Health Education

In all types of group child care, health education for parents and staff seems warranted. It can be provided by student nurses under the supervision of the nurse educator/coordinator. Cust (1980) stated that the overall aim of health education is to change health behavior so that health is promoted and disease is prevented. He noted that the process of changing health behavior through health education is to give people new knowledge, beliefs, and value systems so that they can make meaningful choices about their health behavior.

Parent education and counseling as well as education of the child are becoming increasingly important as more child care is provided in ambulatory care settings. Nurse educators have the opportunity to demonstrate the effectiveness of nursing in planning and implementing practical health education in group child care facilities. Nurses are excellent resource people to staff and parents on such subjects as nutrition, general hygiene, first aid, mental health, communicable conditions and infestations, toilet training, and other daily living skills. They are knowledgeable about general health appraisals and can help parents learn to take temperatures and recognize common symptoms of beginning illness.

Nurses use many forms to transmit health education, including pamphlets, brochures, posters, videotapes, film strips, demonstrations, informal individual and group sessions, formal health education classes, and counseling sessions. Before any health education activity is planned, the needs and attitudes of parents, children, and staff must be considered. Factors that provide an understanding of their life styles and should be taken into consideration are socio-economic level, cultural background, individual development, demographic information (age, sex, educational level), individual characteristics such as status of health, family structure, roles, and functioning. Health education should be designed to aid the parent, child, or staff member to maintain and where possible to enhance his or her life style.

The concept of *self-care* — the individual's role in maintaining health — is a critical aspect of health education. Kagan, Kearsley, and Zelazo (1977) have noted that the home environment seems more influential in sculpting children's early development than child care experiences. Nurses can assist parents in their self-care activities and can also transmit information to children so that they can begin to assume responsibility for their own health.

Provision of Health Services

Health services in a child care facility include developing and maintaining a health record, screening, referral, care of the sick child, and handling emergencies.

Health records. The health record for each child should include information about physical examinations, immunizations, and known health problems and how they are being managed. The name of the child's physician should be a part of the record, as well as where the parents can be located in an emergency. The nurse educator/coordinator or one of the student nurses can monitor the health needs of the children in the facility and maintain information that would permit follow-up if needed. Health information should only be shared with other persons if the parents give permission; the ethical code of nursing requires that the nurse regard the confidentiality of the record.

Health surveillance and screening. Health surveillance is one of the specific roles that the nurse educator/coordinator and student nurses can carry out. Screening is one of the important aspects of surveillance.

It may be routine or specific, but it must be planned carefully before implementation, and parental consent must be obtained. Routine types of screening include developmental, vision, and auditory screening. Specialized screening may occur if there is some indication that a child has an infectious condition; then the nurse may screen other children. Individual children may also be screened if they present with conditions that warrant it: children with nonaccidental injuries may have been injured intentionally, and children with psychosomatic disorders or complaints for which no physical basis can be found may have an emotional problem.

Observation. Part of nursing education preparation is the observation of cues that may suggest health problems. Cues that suggest beginning illness, problems in the family, neglect, abuse, overprotection, overindulgence, and rejection can be identified as a result of observation. Observations will aid child care personnel in understanding the social interactions of the children, which in turn may be reflected in the pattern of transfer of some bacterial, viral, and fungal infections.

Referral. The nurse educator/coordinator and students have a unique role in providing information to families about community resources that can help them and their children meet health care needs. Their knowledge of available resources, their contacts, and their understanding of how to access the resources are valuable contributions they can make.

Emergency and other care. The nurse educator/coordinator and student nurses can help staff and volunteers handle such emergencies as lacerations, nosebleeds, allergic reactions, epileptic seizures, and asthmatic attacks. They can also assist in providing services to children with special needs, such as caring for braces, giving prescription medications, changing dressings, and caring for catheters. The nurse may also obtain cultures when indicated and supervise simple urine tests. Staff health can also be enhanced when a nurse is available to the facility.

Accident prevention. The major causes of accidents in preschool children are automobile accidents, burns, drowning, ingestion of substances and poisons, and falls. Less intelligent children who fail to learn by experience have an increased risk of multiple accidents (Richards, 1980). Helping staff make the physical environment accident-

proof and educating parents and children about safety are important roles for the nurse.

Minimizing transfer of communicable conditions. Identification of conditions that can be transmitted to others is a vital contribution that the nurse educator/coordinator and students can make to a child care center. Parasitic infestations and viral and bacterial conditions that can be transmitted to other children, staff, and family members require knowledge to manage them and prevent their spread. Suggestions on how to minimize spread of various conditions and how to prevent secondary conditions are important responsibilities the nurse would assume. For example, teaching proper handwashing technique would aid in minimizing the prevalence of diarrhea that is a common problem in child care centers.

Research

The nurse educator/coordinator may facilitate studies for master's and doctoral students in areas of improving practice, delivering services, or transmitting knowledge to parents, children, and staff in child care facilities. There is a need to obtain more scientifically sound information about parents from culturally diverse groups and to learn how they perceive and rear their children. Health maintenance and promotion and prevention of illness in child care facilities suggest that there is a need to understand more about health-promoting behaviors, means of coping, adapting, and compliance with the health regimen. The effectiveness of the nurse's role in promoting self-care also needs study. Helping staff conduct market research about their health services is another area in which the nurse scientist could make a contribution.

Selecting Child Care Programs for Nursing Education

The American Nurses Association Maternal Child Health Standards are the basic standards from which specific guidelines for nurses serving in child care settings could be developed. Quality group care for children, regardless of the setting, should include a health component. Nurse educators interested in enhancing care of children

in group settings might consider the following questions in selecting placements for students:

1. What is the philosophy of the child care staff? Does the philosophy include parental involvement? Is a health component clearly stated?
2. Is there interest on the part of the staff in meeting the health needs of the children?
3. Is there enough flexibility so that health needs of the children can be included in the program?
4. Is there a healthy respect for the rights of children and their parents?
5. Is learning encouraged, and are children encouraged to be independent and help themselves?

DISCUSSION

Susan Aronson: I want to compliment you on the nice job you did in pulling together some important concepts, specifically focusing on the role of nurses.

One idea I feel is workable right now is to make sure there is within every child care program — whether it's in the family day care home, where the caregiver herself provides that role, or in the child care center — someone who acts as a health advocate in that setting and who makes sure that health issues are addressed, that the coordination is achieved between the child care program and whatever resources are available. The fact remains that a health professional is unlikely to be affordable. Even medium-size child care centers have trouble keeping such a person employed. Some may, and I don't want to minimize the desirability of that, but we have to find ways to make linkages with what we have.

Juanita Fleming: I think your point is very well taken. You are not going to be able to have a nurse for every one of these centers, or in the family day care programs either. But you could have a nurse who would serve a large number of them. They could hire her on a part-time basis and she could do this work as a part of her role from the university. A lot of nurses want to continue their clinical practice, so

their schools allow them to have their practice along with their teaching.

Susan Aronson: One other thing that I wanted to bring out concerns health assessments. The up-to-dateness of children's health assessments is what we really ought to be looking for, not checkups related to their attendance in child care. There is a common fallacy among both child care professionals and licensing-monitoring people that if you check out a child before he gets in the door, it will guarantee his health for some time forward. What we really need is to make sure that children are up-to-date with the routine health assessments that they should have anyway. We can minimize the distress that we put parents through trying to get a health assessment within a prescribed period prior to enrollment in a child care program. It's really totally unnecessary.

Elinor Guggenheimer: I have a question on the training of child care personnel. When I went to Teachers College, there was a great deal of emphasis on psychiatry, but I don't remember ever receiving any kind of instruction in looking at children and identifying a child who is sick. I have been in child care programs where a child care provider identified a child who was acting very withdrawn as having a psychological problem of some kind, when in fact the child had a high fever and was coming down with measles. I am wondering if that is part of the general training. If you get an M.A. degree, for instance, do you have to have some training in health care, in health identification?

Susan Aronson: It used to be that the answer to that was absolutely no. There was no training going on in the early childhood programs and teacher training programs. But that is changing. Courses in health are beginning to be introduced into associate degree programs as well as bachelor's degree programs.

Betty Caldwell: We have a Department of Health Education in the university. The professors in that department supply some of the lecture sections, which are mandatory in our undergraduate program.

Susan Aronson: Every institution makes its own rules for what goes into its curriculum, but the recognition that health needs to be an integral component is beginning to arrive.

Ellen Galinsky: It is one of the CDA competencies, which I think is a big step forward.

Elinor Guggenheimer: Wouldn't that be a recommendation to make to the universities that are training teachers?

Betty Caldwell: It most surely should. It's in one of NAEYC's booklets concerning standards for teacher training programs. It is one of the criteria.

Susan Aronson: Classically, what it says is that teachers should maintain a safe and healthy environment. That's the catch phrase. It's not defined in any way, and it leaves very unclear what should be included in that education. This is an area in which I agree it would be a very good idea to put a recommendation in. It is happening, but we can reinforce it.

Sandra Scarr: In the training of nurses, the problems of the working parent and the family context are very important for them to know about. In the past, I've had school nurses call me and say, "Your child has a slight cough; come pick him up."

Juanita Fleming: Yes, and nurses today, when they look at children, look at the family. Courses are being changed to parent/child nursing, rather than just nursing of children.

Dana Friedman: What is being done about the child care worker's health, given minimum wage and no health benefits?

Juanita Fleming: I believe that's something to which a nurse can contribute. That was one of the reasons why I said that the nurse should be someone who can work with staff, family, and child.

INTERDISCIPLINARY INVOLVEMENT IN CHILD CARE I: THE RESOURCES

**Alma S. Friedman, M.A.
and David B. Friedman, M.D.**

Editor's note: Because the Friedmans were unable to be present, their paper was presented by Judith S. Palfrey, M.D.

Child care today requires knowledge and skills beyond Mark Twain's comment that we're all experts on children because we've all been there. Child care providers can be most effective when they learn how to use the expertise of professionals from other disciplines. This paper describes the roles that professionals in such areas as health, mental health, social work, child development, education, public service, administration, and design can play in helping the child care setting deliver needed services to children and their families, and it suggests guidelines for child care providers in choosing and working with these consultants.

Child Care Settings as Providers of Services to Children and Families

In today's complex world, child care providers can no longer justify their role solely on the basis of an interest in children. Child care services serve an important purpose in society, providing essential opportunities for the development, socialization, and early education of children and in addition supporting and enriching family life. They must be designed with imagination and creativity to meet these needs of children and their parents. Child care providers must offer a diversity of, and continuity of, services representing the knowledge, skills, and expertise of many professionals in child development, education, health, mental health, social work, administration, and public service. Caregivers do not have to be experts in all these areas, but their effectiveness will be enhanced if they learn how to consult

with and borrow from professionals representing other disciplines. The success of Head Start may be due, at least in part, to early and continuing multidisciplinary efforts in the planning and implementation of the program.

This does not mean that all providers must consult a specialist in each of these fields. It *does* mean that caregivers will benefit from developing sophistication and expertise in selecting appropriate consultants and using their services effectively. When should a caregiver seek consultation? Who should be consulted? How should the consultation process be implemented? What should the caregiver expect of a particular consultant? These are the questions that conscientious caregivers must learn to consider and answer to their own satisfaction if they are to make the best use of experts from other disciplines. Multidisciplinary involvement may be more difficult in family day care than in child care centers, but it can be implemented on a smaller scale if family caregivers learn how to use outside resources. Family day care networks can provide a framework for securing input from other disciplines.

To achieve optimal multidisciplinary involvement in child care, providers should examine their programs and their clientele to determine the needs of the children and the families they serve. They must also look at their present and potential resources. Nothing should be taken for granted. Affluent families may need health education and mental health services as much as economically deprived families. Children from the business and professional community may need developmental services as much as children from working class families. Programs available in the community should be carefully explored. If there are no functioning professionals in a small community, there may be a retired schoolteacher, social worker, nurse, or librarian who could be of help.

Five categories of professionals have skills and expertise that may be invaluable to child care providers:

1. *Health professionals:* physicians, physician assistants, nurses, including public health nurses and school nurses, nurse practitioners, dentists, dental assistants, nutritionists, and health educators.
2. *Mental health and social work professionals:* social workers, psychologists, psychiatrists, marriage and family counselors, family therapists, including the staff of family resource centers, agencies and programs and community workers.

3. *Child development and education professionals:* teachers, developmental psychologists, speech and hearing specialists, occupational therapists, recreational therapists, early education and early development specialists, and child abuse specialists.
4. *Public service professionals:* public health personnel, law enforcement officers, fire protection officers, public and private school personnel, and public library personnel.
5. *Administrative and design professionals:* business management experts, legal advisors, safety engineers, architects, designers, and community relations and public relations experts.

Health Professionals

Child care providers can improve both the quality of their child care services and the well-being of the children and families they serve by consulting with and interacting with health professionals. The most commonly consulted health professional is the nurse. Most child care providers are accustomed to working with nurses; some larger centers, especially those providing infant care, have a nurse — often a pediatric nurse practitioner — as part of their staff. A nurse consultant can function in a number of different capacities: evaluating the physical and behavioral problems of individual children, responding to illness and injury emergencies, evaluating and monitoring the welfare and safety of the children as a group, and developing and implementing creative plans for the health education of both children and parents. Health education is most effective if it is integrated into the ongoing child care program and if it includes education of the staff.

The nurse consultant can assist both parents and child care personnel in finding appropriate medical care. He or she can make medical information about the children available to the child care provider and staff, setting up an appropriate record-keeping system. The nurse consultant can also help to interpret and implement health and safety information relative to licensing and help the provider make the best use of other health professionals and community health and mental health resources. Many child care centers find that their nurse can function effectively working directly with the children as one of the child care staff for at least part of the day.

Physicians and dentists, including pediatricians, family practitioners, and some specialists such as orthopedists, otologists, ophthalmolo-

gists, and orthodontists, play a variety of roles in relation to child care. They may serve as advisors to the provider, serve on the board of directors of some larger centers, offer direct service to the children and families, or assist in any of the areas outlined for the nurse consultant.

Some special comments should be made relative to the role of the nutritionist and the health educator. Not all health professionals feel comfortable in these fields. The health educator can be especially helpful in relation to health habits and safety, while the nutritionist can help with the daily diet served in the center as well as with nutrition information. These professionals may offer advice and counsel, as outlined for the nurse, or they may be integrated into the program in a variety of other ways. Diet, eating patterns, and other health habits are especially important in centers serving low-income families, but all families can use help from creative nutritionists. Age-appropriate food served at regular mealtimes in an appealing manner promotes health and sets a standard for children and families.

Mental Health and Social Work Professionals

The mental health professional most commonly consulted by child care providers is the social worker. Social workers often work for agencies whose goals and procedures are clearly spelled out. In consulting with a social worker or other health or mental health professional working for an agency, therefore, the provider must know the limits and constraints of the agency as well as the orientation of the individual worker if a constructive relationship is to be established. Child care providers must also differentiate between the licensing or certifying worker whose job is to enforce the law and the social work consultant whose emphasis is on improving the quality of life for all participating in the program.

As with health professionals, mental health professionals may interact with child care services on a number of levels. In practice they relate most frequently with the providers of child care and only by referral relate to the children and their families. Mental health consultation may result in changes in the child care program, special handling of an individual child, or referral of child and family for psychological services. In any case, the goal should be improvement in the lot of the individual child and his or her family, including the prevention or amelioration of child abuse and neglect and help for

handicapped children as well as for the children of handicapped adults.

Within a child care center, mental health consultation can be an effective means of preventing provider burnout. It can also be effective in work with individual parents and/or with the parent group.

When there is a family resource center, agency, or program in the community, many child care providers find it to their advantage to work out an informal relationship with it. This can be especially valuable and mutually supportive if there is overlap in the families served. Community consultants including community workers can provide an essential link between the community and the child care service, especially when some of or all the families being served come from minority ethnic groups.

Child Development and Education Professionals

Child care providers often consult child development and education professionals with reference to an individual child, but some also find it worthwhile to consult experts in this field about the overall child care program. Speech and hearing specialists can be especially helpful in working with an individual child. The developmental specialist can evaluate, set goals, plan action, and monitor progress. Such planning and monitoring will not only be of help to child and family but will relieve the inevitable frustration of caregivers struggling with a child whose progress may be slow or uneven or whose behavior may be unusual or disruptive.

The child care provider may need assistance in identifying and reporting child abuse. It is wise to have a knowledgeable consultant from this field available to evaluate individual situations. Providers can also get help in identifying those families that appear to have the potential for neglect and/or physical, emotional, or sexual abuse and referring them to appropriate professionals. They can learn how to help abused children avoid behavior that might invite abuse, including teaching social and coping skills to children who are at risk for abuse.

A special word about sexual abuse is in order because of recent media emphasis on several cases. It is important to state that the huge preponderance of sexual abuse, and it is frighteningly common, occurs in and around the home by a person well known to the child, not in child care centers. Sexual abuse is usually a carefully planned act. The perpetrator seeks out a situation which brings him or her into close

contact with children, then gains the confidence of the children, parents, and — in the case of the child care setting — staff. Because opportunities for privacy in most centers are difficult to find, collusion with someone inside the setting is usually necessary. The obvious defenses against this kind of infiltration are care in choosing and careful supervision of personnel and opening the child care service to parents and the community, allowing and encouraging parental monitoring and involvement.

But how does the child care worker defend against even the rare accusation? Appropriate legal consultation when there is any suspicion that an accusation may be forthcoming is the center's and the worker's best defense. Exploring a situation of this kind requires great skill and a level of objectivity that usually cannot be provided within the center where the problem arises. Consultation and guidance from an outside expert should be sought. In addition, carefully detailed, confidential, written records should be kept of troubling situations.

Public Service Professionals

For many child care facilities the only contact with the health department relates to licensing and certification standards. The relationship can go beyond that. The local health department often has on its staff knowledgeable professionals who can offer advice and counsel to child care providers. Public health nurses can play a variety of roles, and infectious disease specialists can help in the area of disease, infection, and contagion. Local hospitals, medical centers, and medical schools may also be a source of consultation.

Caregivers should know their local law enforcement officers and fire fighting personnel. Representatives of these services often appreciate being asked to participate in or contribute to the ongoing program and can offer exciting and educational programs and field trips.

Child care providers should know the schools in their community or neighborhood. School personnel such as principals, teachers, school nurses, school social workers, and pupil services personnel may be invaluable resources. It also helps to know what will be expected of the children when they enter school. Local colleges and universities may be a source of professional assistance ranging from teachers and student teachers to experts and trainees in many of the disciplines already discussed. High school students may prove to be reliable caregiver assistants if they are properly supervised. The public library

is a rich resource for enterprising caregivers. Libraries often have programs for children, and many librarians have skills that could enrich a child care program.

Administrative and Design Professionals

Safety engineers, architects, and designers can plan a safe, developmentally appropriate environment for the children, while keeping in mind the needs of the adult caregivers. Business management experts can help set up an efficient bookkeeping and accounting system. With the help of legal advisors, child care services can be planned and implemented in a manner that will protect the director and staff from unwarranted lawsuits.

How to Use and Work with Consultants

Remembering a few simple rules will help child care providers to make the best use of professionals in other disciplines as consultants to their programs.

1. Do preconsultation homework. Learn as much as possible about the consultant's field and what his or her speciality can offer.
2. Know the consultants and the agencies they represent before you need them. Don't wait for an emergency to make the first contact.
3. Choose consultants carefully. Even highly qualified and well-recommended experts in a field may not be right for the needs of a particular child care provider. Consultor and consultee must communicate well. Learn as much as possible about the problem-solving style of the chosen consultant. Choose consultants you can trust and respect and with whom you can communicate.
4. Explore referral resources available in the community. A specialized consultant may not be familiar with these services. In communities where services are limited, alternatives may be uncovered in this way.

5. Know when and how to involve the parent group in the consultation process. There may be potential consultants in this group, but choose with care for reasons of confidentiality and good public relations.
6. Develop a small group of knowledgeable contacts from the community to whom you can turn when you need advice relative to a particular situation or problem. Effective caregivers use their community contacts well.

II: A MODEL PROGRAM

Judith S. Palfrey, M.D.

The Brookline Early Education Project (BEEP) was a pilot program funded by the Robert Wood Johnson Foundation with the purpose of determining what would happen when the public school system of a town took responsibility for the early identification of developmental dysfunction and for the early intervention for problems as well as for a preventive early childhood program (Pierson, 1973). It was an interdisciplinary program that provided diagnostic work-ups and early childhood education to a population of children from birth to entry into kindergarten.

This paper describes the research findings of the project and also discusses the barriers to successful interdisciplinary work in child care settings.

The Brookline Early Education Project

The impetus for the Brookline Early Education Project came from the superintendent of schools in Brookline, who was struck by the fact that his kindergarten teachers were telling him that between 10 and 15 percent of the children coming into kindergarten had health or

developmental problems that they could identify immediately or within several months of the child's entry. The superintendent wondered why it was that these problems had not been recognized prior to kindergarten and why nothing had been done about them. He set about to establish a program in which identification of health and developmental dysfunction could be carried out as early as possible, followed by targeted intervention.

Because this was a public school system, the program was established for everyone in town, but participation was on a voluntary basis. A cohort of children was recruited in 1972 and 1973. The children were enrolled three months before birth. From birth to age two, they received an intensive family-oriented program, and from age two to age five they received a center-based program.

Interdisciplinary teams consisted of early childhood specialists, child psychologists, physicians, and nurses. The original design of the program did not include a social work position, but within a very short time it became clear that social service work was essential, and by the end of the program 30 percent of the BEEP enrollees had had contact with a social service provider, many receiving intensive interventions.

Many of us in the medical profession were struck by the fact that the public school teachers in the program came to their work with an orientation exclusively toward children, and children in groups. What was new for them in the early childhood context was the interaction with the families. It had not been part of their educational training, and some of the teachers found it difficult to find where to draw the fine line in the professional relationship with the mothers. Initially, it was decided to have a rather informal working relationship between teachers and families; communication was on a first-name basis, for instance. Some of the teachers developed such a friendly relationship with the mothers that on at least one occasion it became difficult to take on a more professional helping role when that was indicated.

The interdisciplinary working of the program had three distinct benefits. First, from a service point of view the children in the program received comprehensive care, including health screening, sensory screening, psychological screening, and early childhood education. Second, the training of providers in early education and pediatrics was extensive. Third, BEEP served as a major source of research information. It was through the sharing of the various disciplines that we began to understand more about young children and, I believe, actually to prove the superintendent's hypothesis (Pierson, 1973) that it was indeed possible to identify quite early many of the children who

would ultimately go on to have problems in the elementary school years.

Research Findings

First, the interdisciplinary evaluation of children was found to be an effective system for early diagnosis. Studies of the diagnostic process indicated that accurate identification depended on the ability to monitor young children over time. The most vulnerable children in the study were those who showed the persistence of risk patterns over two to three examination periods. As a result of the initial analyses, it was felt that the examination periods yielding the greatest amount of information were at 2 weeks, 24 months, 42 months, and entry into kindergarten (Palfrey, Levine, & Pierson, 1984).

Second, when we looked at four areas of early concern — health, cognitive ability, motor development, social and emotional adjustment, and attentional difficulties — it was interesting that the area of concern that held the tightest relationship with each of the other areas and for which there was the least treatment effect was attentional disability (Palfrey, Levine, Walker, & Sullivan, 1985). That is to say, children with early attention problems tended to be those who had persistent disability in kindergarten and well into second grade.

Third, we were convinced in our own minds (it remains to be seen whether others will accept these findings) that there was a subsegment of children whom we could identify as early as 42 months of age who subsequently went on to develop significant learning problems (Palfrey, Levine, & Pierson, 1984). This kind of early identification of learning problems is not happening throughout the United States. Our current national study of P.L. 94-142 indicates that there remains a significant challenge in the area of early identification, especially of mental retardation and learning disabilities (Palfrey, Butler, Singer, & Walker, 1985).

Fourth, socio-economic status (as defined by the mother's education) was a very strong predictor of early disability, though by no means the only one. When we looked at resiliency among the children, the important protective factors were female gender, the mother's relatively higher level of education, and the existence of few associated problems (Palfrey, Levine, & Pierson, 1984).

Evaluations of the educational program for children in BEEP have demonstrated that public school-sponsored early education was

effective for many of the children (Pierson et al., 1983; Pierson, Walker, & Tivnan, 1984). The overall results favored BEEP participants in a second grade observation when compared with a group of randomly selected comparison students. While 14 percent of BEEP children had difficulty with classroom learning behaviors (as measured by six ten-minute structured observations by independent, trained observers), 28 percent of randomly selected comparison children demonstrated such difficulty with classroom learning behaviors. In addition, 19 percent of the BEEP children were unable to decode words or comprehend stories in a 2/2 level basal reader during the spring of second grade, compared with 33 percent of the randomly selected comparison group.

The effectiveness of the BEEP program varied with the educational level of the child's parent. For children whose mothers had high levels of education, there was a "dose-response curve" for increasing levels of program intensity, with BEEP children at each intervention level showing better performance than matched controls on second grade outcomes. By contrast, for children whose mothers had lower levels of education, improved performance over controls was found only among the groups who had received the high and middle outreach programs, and no improvement over controls could be documented for the youngsters in the low-intensity program.

Barriers to Interdisciplinary Work

It is important to recognize at least four barriers to interdisciplinary interactions:

1. *Distrust and miscommunication among professionals.* This is still a field in which psychologists, education specialists, pediatricians, and nurse practitioners are all feeling their way. There remain many questions for which no one has the answers, and occasionally the posturing of experts leads not to answers but to controversy and confusion for parents. Until there is a better general understanding of early childhood development and professional roles, this will continue to be the case.
2. *Inadequate payment mechanisms for consultations.* Many child care providers cannot pay for needed consultative services, and service programs are not set up to offer free services. This is a major issue for all early childhood services.

3. *Inadequate training of professionals for community work.* Very few physicians and nurses are trained to deal with the different tempos and expectations of community work. There is a major need for more community service training programs.
4. *The low esteem in which the whole child care enterprise is held.* Unfortunately, work within child care centers is not considered serious work. If anything can come of this conference, I would hope it would be a call for more recognition of the excellent work that child care workers, early education specialists, pediatricians, and others put into creating a safe and nurturing early experience for our nation's children.

DISCUSSION

Bettye Caldwell: Judy and Juanita both, I would like to ask a question. I have been involved in child care for twenty years, and for twelve of those years I was a child care director. Whenever we had a medical person on the staff, the teachers and caregivers were afraid to take any action, make any decision, or make any recommendation about a health issue. It has always been difficult to deal with this, to give these caregivers confidence and the feeling of esteem that Juanita stressed. How do we give them that confidence to make decisions?

Susan Aronson: I have had some experiences with that in working with a large number of child care programs, both family day care homes and centers, that had access to health professionals, and especially with those that had nurses right there. The nurses learned to say, "Okay, what do you think you should do?" when the caregivers came to ask. Eventually the caregivers got tired of hearing that, so when they really did know what to do, they tended not to come so much.

Sandra Scarr: There are difficulties in bringing more highly trained people into a child care setting. As you say, others then simply abdicate responsibility for what they used to do, and defer. It may be helpful overall, but it's also very much more expensive.

Judith Palfrey: Part of the problem has to do with the training of physicians and nurses. We have to teach them to have a little humility and to listen to the teachers and caregivers, who know a lot about children and can teach them something.

Susan Aronson: Training health professionals to interrelate with other kinds of professionals is very difficult. I have worked on that also in my faculty role, and I find that they can relate to it through the systems that we have taught them before. We teach them to consider a child care program as a patient: you collect subjective information by taking a history from the child care program and then you collect objective data by making some observations yourself. You make an assessment of the problem, as though you were looking at a patient record, and make a plan, involving all those who are to be affected by the plan. Then you follow through to be sure that the plan will work. You can teach medical people to act appropriately if you teach them in language they are used to, so they don't feel so strange in that environment.

Juanita Fleming: I'd just like to underscore that it's a two-way thing: the health professional learns from the teacher, and vice versa. We are a team. There has to be an attitude of mutual respect, an attitude that we are here to work together to do what's best for the family, not that there's my territory and your territory.

Elinor Guggenheimer: I'm glad that Juanita said what she did, because a teacher or caregiver who is with a child all day long can observe things that nobody coming in and seeing a child briefly will. I know of one instance where a teacher noticed that a child who had been assumed to be backward was very inattentive whenever there was reading. A hospital didn't detect deafness, but the teacher did.

Michael Yogman: In relationships between nurse and teacher, pediatrician and nurse, there's a real analogy to the relationship between caregiver and parent and the need for the same kind of mutual respect and two-way communication with the parent, who obviously knows the child best.

Sandra Scarr: I'd like to go back to something you mentioned in the area of turf issues. I am a little concerned about the child care field in general in this respect, because we are now producing too many physicians and Ph.D. - level developmental and clinical child psychologists to be absorbed comfortably. These people are going to be looking for new turf. I see them encroaching into education, into social service work, and in what used to be defined as child caregiving. I don't have a solution to this, but I think it's something we ought to be alert to.

Betty Caldwell: Your comment is very applicable to some of Susanne's comments, and to Dana's. I think a corollary of what we are

saying is that, across the board, we have to have more respect for each person's contribution to the welfare of children, families, and life.

MAINTAINING HEALTH IN CHILD CARE SETTINGS

Susan S. Aronson, M.D.

Child health professionals work with parents and children to promote the physical, emotional, cognitive, and social health of children from birth to adulthood. With increasing numbers of single-parent families and families where both parents are in the labor force, physicians need to relate to the extended network of adults who contribute to the child's well-being. About a third of the nation's children are in child care (Hayghe, 1984; Bureau of Census, 1983), and child care professionals are among those responsible for protecting the child's health and safety.

Although few valid studies of the incidence of health problems in child care are available, current information suggests that there are three major targets for promotion of child health in day care: injury control, prevention and management of infectious diseases, and attending to the health needs of individual children. This paper outlines the measures that should be taken within the child care setting to prevent injuries and the spread of disease and describes how child care providers and health professionals can work together to ensure that each child in the program receives appropriate medical care.

The paper also discusses how the child care setting can promote child health through health education and modeling of healthful practices. Not all child care providers are knowledgeable about health concerns, however, and the paper points to the need for adequate regulations and competent monitoring of compliance with them.

Significant Health Implications of Child Care Use

Only a few studies have reported data on the health status of children in child care. The Head Start health program detects and arranges for correction of vision and hearing defects and anemia. Children in Head Start achieve higher levels of health care than comparable children not in the program, have fewer absences from school, and perform better on physical tests (Collins & Deloria, 1983). National surveys of immunization status reveal that child care has a strong positive effect on the achievement of protection from vaccine-preventable diseases (Hinman, 1986).

Health promotion opportunities abound in child care. By modeling healthful behaviors in nutrition, dental health, behavior management, and discipline, caregivers and skilled parents can show other parents successful strategies for child-rearing. Experiencing health-promoting care in child care is important in itself, and the significance of these experiences is magnified by the potential effect on parental caregiving.

Little scientific information has been collected concerning health risks associated with child care, however. No surveillance systems have been established to collect data on the incidence of health problems in child care. On the basis of the incidence of health problems that affect children generally, three areas can be examined for their health implications in the child care setting: injuries, infectious diseases, and providing for the health needs of individual children.

Injury Control

Without incidence data, we do not know whether children are safer or at increased risk of injury in child care. A study of 422 insurance claims filed in 1981-82 (Aronson, 1983) showed that the products most frequently associated with the most severe injuries were, in descending rank: climbers, slides, hand toys and blocks, other playground equipment, doors, indoor floor surfaces, motor vehicles, and swings. Of those injuries where the location of the accident was specified, nearly two-thirds occurred on the playground. Climbers accounted for the greatest number of most severe injuries.

The following corrective actions can be recommended:

1. Modify climbers, slides, and swings to reduce injury or remove them entirely. The U.S. Consumer Product Safety Commission

(1981a, 1981b) recommends limiting the maximum climbing height to six feet; mounting climbing structures over at least an eight-inch depth of loose fill material, such as shredded tires, pea gravel, or pine bark; spacing playground equipment far enough from other structures and traffic patterns to avoid collisions; covering sharp edges and exposed bolts; teaching children how to play safely on playground equipment.

2. Supervise activities associated with more frequent and more severe injuries more closely than other activities. Staff should be especially vigilant on the playground and use large-muscle play time as an opportunity to teach safety rules.
3. Design indoor facilities to reduce risk of injury. Doors should have slow closing devices and beveled edges; open floor areas should be broken into smaller units to limit running where it is unsafe.
4. Work with parents to prevent motor vehicle injuries through use of age-appropriate seat restraints and close attention to driver training, drop-off and pick-up routines.
5. Identify other high-risk areas through a systematic study of injuries within the individual child care program and develop preventive strategies.
6. Train child care staff in injury prevention and management, including hazard control in the building, on the playground, and on field trips. Staff should also be proficient in first aid and emergency measures.
7. In planning staff/child ratios, be sure enough adults are present at all times to evacuate all children safely in an emergency.

Prevention and Management of Infectious Diseases

Young children who are brought together in groups for care have increased exposure to infectious disease agents. Child care programs that implement appropriate health policies help prevent transmission of infection, however, by requiring that children receive immunizations and routine health care and by giving instruction in hygiene, nutrition, and management of minor illness.

Much of the current scientific information on infectious disease

problems in child care is based on retrospective evaluations of outbreaks, not on prospective assessment of the incidence of disease in a valid sample of the population. Therefore no accurate assessment of the relative risk of infection from child care attendance can be made. Few studies have evaluated the specific characteristics or practices of child care settings that promote or inhibit transmission of disease. Outbreaks of gastroenteritis, bacterial meningitis, hepatitis A, and vaccine-preventable diseases have been documented in child care programs. Recent reports of higher incidence of shedding of cytomegalovirus (CMV) among child care staff and children have raised concern, but such reports must be kept in perspective; the virus is widespread in the community, and immunity-producing infection during childhood is common and usually occurs without any evidence of illness.

Children in child care are being involved in testing and use of new vaccines to prevent childhood diseases that are suspected to be more common or more easily spread in child care settings. Children in child care may be among the first to benefit from the new *Haemophilus influenzae* type b vaccine and a proposed rotavirus vaccine.

Day care personnel, health professionals, and parents are concerned about the correlation between entry into child care and the frequency of illness. In one study where this issue has been examined, it seems that the overall burden of respiratory infection is not greater for children in day care but that there is a shift of illness to younger ages (Henderson & Giebink, 1986). Beyond the first year of life, however, children in child care in one study (Loda et al., 1972) had a lower incidence of respiratory infection than the children in another study (Dingle, Badger, & Jordan, 1964) who did not receive child care.

Haemophilus influenzae type b is a less frequent but more serious respiratory pathogen that seems to pose an increased risk for children in child care. A vaccine is now available to protect children over two and some as young as eighteen months. The risk from this disease should be brought under control as newer, more effective vaccines are released.

Studies show that the incidence of gastrointestinal infections in day care programs where no special handwashing is practiced is double that among children receiving care in their own homes (Black et al., 1981; Pickering & Woodward, 1982). With conscientious handwashing, the incidence among child care children drops close to the levels found among children not in child care.

Useful measures for controlling infectious disease include:

1. Assigning soft toys to individual children when possible.
2. Sanitizing mouthed objects by washing and dipping in a bleach solution.
3. Establishing routines for handwashing for staff and children.
4. Establishing routines for handling fecally contaminated materials and surfaces.
5. Enforcing mandatory immunization for children, staff, and volunteers.
6. Establishing reasonable, scientifically supportable policies for excluding children with transmissible infection.
7. Arranging for easy access to health consultation for every child care program.
8. Providing at least yearly inspection of every child care facility by a qualified sanitarian.

Providing for the Health Needs of Individual Children

Since nonparental care is used by most families, a discussion of child care plans is a valid part of a well child history-taking from the prenatal interview onward. The health professional can use knowledge of the family, of the child, and of the available community resources to help families find appropriate child care settings. Child care programs can help educate local health professionals by contacting them about child care children who are their patients, sending them newsletters and program brochures, and inviting them to visit child care facilities as guests, parents, or paid consultants.

Child health providers use periodic health assessments to maintain surveillance for early signs of correctable problems and to provide health-promoting advice and services. Despite pediatric advocacy, many children do not receive preventive care as frequently as is appropriate to their age and developmental status (U.S. Department of Health and Human Services, 1981a). Some of these underserved children are in child care. Frequent contact between caregivers and parents provides many opportunities for child care providers to promote appropriate seeking of health care. Where private care is

unavailable, children should be referred to appropriate public health agencies. Child care staff can often help families with special health or social problems find services. Sometimes screening services such as those for vision, hearing, or anemia can be provided most efficiently for a particular group of children at the child care site.

Caregivers can contribute their observations of a child's behavior to other assessment data being gathered by the child's health professional. By sharing their observations, caregivers help health providers shape recommendations for promoting the healthy development of individual children.

To be effective, communications between health providers and child care staff must be two-way. Once a child is enrolled in child care, there should be routine exchange of information about the child between the physician and the child care provider. Usually parents will convey information between doctor and caregiver, but in special situations, and with parental consent, more direct contact between staff and doctor may be helpful.

Appropriate topics for routine communication between a child's physician and child care provider include: (1) current state of health and nutrition, including any special needs for management of the child in health and illness; (2) growth and development of the child in relation to adaptations of the child care facility or curriculum that might be required; (3) social and behavioral skills of the child; and (4) strengths and weaknesses of the family that affect their care of the child.

Managing Health Problems

Because all illness and injury are not preventable, measures to manage health problems in child care are needed. Staff need training on first aid, management of minor illness, and emergency procedures. Emergency contact information must be kept up-to-date for each child. Parents must always be available to give at least telephone consent for medical treatment.

Plans must be made by each family and by the child care program for care when children become ill. While home care by parents may be an ideal approach, this alternative is not practical and probably not necessary for every illness. Employers need to modify sick leave policies so more parents can use their benefits to care for their children during significant illnesses. If sick children are to remain in child care,

provision must be made for supplemental staffing so the needs of all the children in the group are met. New options for care of ill children are being explored, including sick bay in regular child care centers, special centers to provide care for sick children, family day care homes for ill children, and in-home caregivers for parents who can afford the high costs of home health workers. As alternative options are developed, child care and health care professionals must advocate for children to be sure that such arrangements do not place children with unfamiliar caregivers in unfamiliar settings.

The Role of a Health Consultant for Child Care Programs

Increasingly, child care program administrators are becoming aware of their need to have a nurse or doctor who will serve as a program consultant: The role of the health consultant includes providing and interpreting the advice of national standard-setting bodies and helping to find solutions to health problems. Another role for health professionals is the training of child care providers and staff. Information should be provided in preservice and in-service training and recorded for future reference in the program's health policies. Topics to cover include: (1) staff health; (2) inclusion or exclusion of children with health problems at enrollment and on a day-to-day basis; (3) daily admission and ongoing surveillance for infection and illness; (4) care of ill children; (5) management of injuries, emergency preparedness, evacuation, and first aid; (6) safety surveillance in the facility, on the playground, and on trips; (7) transportation safety for routine pick-up and drop-off, as well as on trips; (8) medication administration; (9) routine health assessments for children; (10) nutrition and food and formula handling; (11) sanitation routines, including handling of contaminated clothing and furnishings, as well as routine cleaning; (12) dental hygiene practices; (13) provision for bathing or swimming, if appropriate; and (14) a mechanism for routine annual review and revision of health policies by child care staff, parents, and health professionals.

Community Responsibility for Health in Child Care

It is unrealistic to expect that parents will provide adequate monitoring of child care quality on an ongoing basis. Parents of young children often lack the experience required to recognize hazardous conditions, and their need for care may bias their evaluation. Maintenance of adequate regulations and competent monitoring of compliance is essential to protect young children who are in child care. Many states lack specific regulations about health, safety, and sanitation. Inspections are not uniformly conducted and often omit observations for significant health risks (U.S. Department of Health and Human Services, 1981b; Kendall & Walker, 1984; Schrag, 1984). Because both inspectors assigned to child care and child care providers are often not trained in child health, regulations must be explicit. Rational application of realistic guidelines will help protect staff and children from significant health and safety risks in the child care environment.

DISCUSSION

Michael Yogman: There is a real opportunity for the child care providers to be a source of information to the pediatrician and the parents in a developmental assessment for behavioral problems. They can provide data on the child that can really help the problem-solving.

Susan Aronson: The linkage between the child care provider and the health network is very rewarding, not only in terms of data exchange about the child but also in identifying children who never make it to the health care system for routine preventive health services. There is also an opportunity for the child care providers to function as marketing representatives for good health providers. There is nothing wrong with a child care provider saying, "I know that Dr. X is a good doctor," if a parent is looking for medical care services.

Sandra Scarr: I've learned a great deal from what you were saying. It really was very helpful, and I started to think back to one of the questions I keep asking myself, about professionalization and the provision of high quality care and the economic problems of doing so. Let's consider: most children are in their own homes for most of their growing-up time. There are homes that don't have standards that high.

Many don't, most don't. I don't think I ever went through the sanitizing routine for my babies' toys.

Susan Aronson: You didn't need to, because you were not aggregating children from more than one family in groups. You were only sharing organisms within your own family. In group care and child care there is a heightened opportunity for exchange. So we need to step up the sanitation routines. You can get away with exchanging organisms in your own household; you all share the same family of germs. But when you start mixing families, the risks increase, and we have to respond to that.

Sandra Scarr: Well, then, what about the safety standards? Most family day care providers use the recreation rooms in their own homes, and they probably have sofas on which toddlers can try to climb and they probably have a carpeted floor. How much are we going to ask of the neighborhood family day care provider? What can she afford to do that will make the system work better, but maybe not as perfectly as we would like?

Susan Aronson: The answer is to avoid significant risks in your recreation room. You don't have to put up a trapeze over linoleum. You don't have to introduce obvious hazards. We're not asking a family day care program to be barren or sterile. We're not saying that all injury is preventable, but many of the significant ones are. We know that there are certain things that tend to increase the injury risk, so you can avoid them. Don't use unprotected space heaters, for example, and anchor swings properly so they won't tip over. What we're asking is that family day care homes and centers use the safety standards we advise parents to observe.

Sandra Scarr: That makes sense.

Betty Caldwell: I think that's an important point, though, Sandy, that this may also be conducive to that attitude of superiority that the staff sometimes feels towards the parents. "We maintain such high standards of sanitation and safety here, and yet he goes home and his teeth aren't brushed and his bottom isn't cleaned" and so on. This could well be one of those areas of incipient conflict between the staff and the parents.

Rebecca Fewell: I want to reiterate the point about modeling. I think what you have in the child care center, you model for the home. Your

concern was that this is too expensive, and I'm saying I don't think most of it is. It's cheap to wash your hands.

Betty Caldwell: It is, but it's hard to model these things in the parenting-on-the-run that Mike talked about. Some of these things are difficult to model unless you can get parents to spend time in the center.

Susan, Juanita, and Judy, we have to make all sorts of efforts to get these things that you suggested out to people in the field. There are a number of publications along these lines, but I think that just as the media has been saturated with the sexual abuse problem, we really need to have a saturation campaign to get these simple bits of information out so that they can be used. That's one of the goals of this Round Table, to see what we can do to help.

Susan Aronson: If I might, I'd like to give a postscript to those of you who have not seen some of the materials that have become available. The Centers for Disease Control (CDC) has just come out with a kit that includes a booklet for child care directors, for parents, and for caregivers, and posters on infectious disease control. CDC printed one kit per licensed center, to be distributed free by the state health departments through whatever mechanism they choose. It's also available for sale through the Superintendent of Documents for \$4.00. Another resource for materials is the Preschool Enrichment Team in Holyoke, Massachusetts. They have made up beautiful posters on hand washing and diaper changing. The Seattle, Washington, Health Department has published a very nice health manual. The Massachusetts Department of Health has developed a comprehensive health component guide book. Materials are beginning to be available, and we should encourage people to obtain and use them.

PROMOTING QUALITY IN CHILD CARE PERSONNEL

Marilyn M. Smith, Ed.D.

Although some politicians, researchers, and child development professionals continue to pursue the question of what long-term harmful effects will result from participation in group programs at an early age, the question for the 1980s is not whether children should participate but how children in group care can achieve optimal development — socially, emotionally, physically, and cognitively (Clarke-Stewart & Fein, 1983). The most important issues have become "What is a good quality child care program?" and "How can good quality programs be provided for all children?"

Research on the quality of child care programs has been slow to emerge. Only recently have studies been conducted that attempt to measure the effects of various dimensions of the quality of the program on outcomes for children. From the few existing studies, at least one strong conclusion can be drawn: the most important determinant of the quality of the program is the adults with whom the child interacts on a regular basis (Ruopp et al., 1979; McCartney et al., 1982; McCartney, 1984; Howes & Rubenstein, in press). The most consistent finding from this research is that positive outcomes for children, both cognitive and affective, are related to the presence of caregivers with specialized training in early childhood education and child development. In terms of actual teacher behavior, the most salient determinant of the quality of children's experiences is the amount and quality of adult-child verbal interaction (McCartney, 1984).

It is therefore critically important that child care programs be staffed by competent, well-trained adults. This paper presents the obstacles to maintaining good quality child care personnel and discusses some of the ways that the early childhood profession is attempting to overcome them. Specific initiatives of the National Association for the Education of Young Children, the nation's largest professional association of early childhood educators, are described.

The Obstacles to Maintaining Quality Child Care Personnel

Informal conversations with child care directors inevitably reveal that their most difficult task is finding and keeping well-qualified staff. A recent survey by the Child Care Information Service (1985) revealed that the most pressing issues identified by center directors were staff training and enhancing the professional status of child care providers. Without question, the major obstacles to maintaining quality child care personnel are low salaries and low status. As long as staff members in child care programs continue to earn minimum wage or only slightly higher, it will be difficult to keep well-qualified individuals. But low salaries alone are not the major obstacle to maintaining competent staff, since many people gladly accept lower pay for a rewarding, high status position. The devaluing by society of work related to young children and the subsequent low status afforded child care workers are major contributors to the problem.

Working with young children in group care settings is a difficult, stressful job that requires specific knowledge and skill. Meeting the needs and enhancing the individual development of a group of twenty children for eight hours a day is quite different from caring for one's own child in the home. There is a widespread assumption that anyone who loves young children or who has been a parent is qualified to work in a child care program. This premise is not only false but damaging to the image of the child care professional.

NAEYC Initiatives to Promote Quality Child Care Personnel

The National Association for the Education of Young Children (NAEYC) now has a membership of over 50,000. The purpose of NAEYC is to improve the professional practice of people who work for and with young children. Recently, NAEYC has undertaken several new initiatives directed toward the goal of improving and maintaining the competence of child care personnel. These initiatives include the development and application of guidelines for early childhood teacher education programs, support of the Child Development Associate (CDA) credential, and development of a national, voluntary accreditation system for early childhood programs.

Improving Professional Preparation of Child Care Personnel

The knowledge and skills required of a teacher of young children are different from those required of an elementary school teacher. One of NAEYC's major efforts on behalf of the quality of early childhood teacher preparation was to develop *Early Childhood Teacher Education Guidelines for Four- and Five-Year Institutions* (NAEYC, 1982). These guidelines were developed "to establish a standard of excellence for new and existing early childhood teacher education programs" in colleges and universities. As more institutions add early childhood teacher preparation, it is critical that those programs prepare students adequately for their role.

NAEYC's guidelines have been approved by the National Council for Accreditation of Teacher Education (NCATE), the major accrediting body of teacher education programs. Baccalaureate degree programs in early childhood education that seek NCATE accreditation must demonstrate their compliance with the guidelines.

A second initiative of NAEYC is the development of *Guidelines for Early Childhood Education Programs in Associate Degree Granting Institutions* (NAEYC, 1985c). Increasingly, two-year colleges are becoming centers for child care training, particularly of individuals who work directly with young children in classrooms. NAEYC's two-year guidelines establish quality standards and define a common core curriculum for preparing personnel to enter the early childhood profession.

Child Development Associate National Credentialing Program

Over the last eleven years one of the most effective programs for maintaining quality in child care has been the CDA National Credentialing Program, a federally funded, competency-based training and assessment system for child care personnel. Throughout its history, NAEYC has actively supported the CDA program as an effective staff development tool. The CDA program is especially valuable in providing professionally developed, national criteria defining competence in child care personnel. The competencies are used in numerous training institutions throughout the country, providing guidelines for curriculum development and goals for training. Finally, the CDA program provides an assessment system that recognizes competence in child care personnel by issuing credentials to individuals

(CDA National Credentialing Program, 1983). Future goals for the CDA program include greater participation by the diverse field of early childhood educators, development of standards for and a method of monitoring the quality of CDA training programs, and more direct participation by the profession in the administration of CDA; the latter has now begun with NAEYC's assumption of direct management responsibility for the program.

Accreditation of Early Childhood Centers and Schools

The most comprehensive mechanism for maintaining quality in child care personnel is NAEYC's development and initiation of a national, voluntary accreditation system for early childhood centers and schools. The accreditation system was developed over a three-year period with the input of thousands of early childhood professionals throughout the country. In 1985 a new division of NAEYC, the National Academy of Early Childhood Programs, was created to administer the accreditation project. A complete description of the system is provided in *Accreditation Criteria and Procedures of the National Academy of Early Childhood Programs* (NAEYC, 1984a).

The purpose of the accreditation system is to improve the quality of early childhood programs and identify those programs that provide good quality care and education for young children. Prior to NAEYC's initiative, no national set of standards or system of accreditation existed to ensure that high quality was maintained in child care programs. State licensing standards were the only existing system of quality control for child care programs, and they vary enormously (Johnson et al., 1982) and at best are designed only to ensure a minimum level of protection for children (Morgan, 1982).

The implementation of a national accreditation system is expected to have a significant impact on the field of early childhood education. The accreditation system is based on NAEYC's Criteria for High Quality Early Childhood Programs, the standards by which quality is measured. The criteria were developed from a review of the research findings of the effects on children of various components of a group program. They were further refined by incorporating the suggestions of thousands of child care practitioners.

The accreditation process, as experienced by an early childhood program, is summarized below:

Step 1: Self-study. The program first conducts a self-study — an in-depth, internal program evaluation designed to provide an opportunity for active involvement by staff, administrators, and parents. The self-study materials, derived from the criteria, include four parts:

1. *Early Childhood Classroom Observation*, used by teachers and the director to rate the curriculum, the physical environment, provisions for health and safety, and the quality of interactions among staff and children.
2. *Administrator Report*, used by the director to evaluate the administrative aspects of the program.
3. *Staff Questionnaire*, addressing staff issues, administration, and program implementation.
4. *Parent Questionnaire*, giving parents an opportunity to evaluate the quality of interactions among staff and parents.

During the self-study, program personnel measure their own performance against the criteria. Once the center personnel feel their overall compliance with the criteria is sufficient, they report their compliance on a written Program Description.

Step 2: Validation visit. The accuracy of the Program Description is then verified during an on-site visit by trained professionals called *validators*. Validators use the same observation instrument the center personnel used and compare their results with those reported by the center. Validators also examine various sources of evidence, including documents, to ensure that the Program Description is as accurate as possible.

Step 3: Accreditation decision. The final step in the process is the accreditation decision. It is made by a three-member commission that considers the validated Program Description and applies professional judgment to determine whether the center's overall compliance with the criteria warrants accreditation.

The potential of the accreditation system for improving and maintaining quality in child care personnel is great. The self-study process has the greatest potential for influencing quality. The impetus

for self-evaluation and self-improvement is provided by the incentive of achieving accreditation. Since the system includes actual observation and materials to facilitate that program improvement, it is more likely to achieve its goals. Because the system is voluntary, the motivation for participation comes from within the program and improvements are more likely to be real and lasting.

When NAEYC field-tested the accreditation in thirty-one early childhood centers in four states, the most encouraging finding was that conducting a self-study was an effective staff development tool and that participation in the process resulted in change (Bredenkamp, 1985). The self-study process not only identified areas in need of improvement but identified program strengths; many child care professionals reported that they felt reinforced for the good work that they were doing on behalf of children and families.

By establishing standards of quality and a process designed to involve professionals in self-study and self-improvement, NAEYC's accreditation will have a major impact on program quality, particularly the quality of child care personnel. The standards for staff qualifications are high, and they stress ongoing in-service training through both formal course work and informal workshops and conferences. Participation in the self-study/accreditation process itself is a major staff development effort.

Insurance Benefits

The final mechanism for maintaining quality in child care personnel is improving benefits for these personnel. NAEYC has negotiated health and life insurance packages available to NAEYC members at group rates. For the majority of child care programs the size of the staff is not large enough to warrant competitive rates for health insurance premiums. With NAEYC's group rates, more child care programs will be able to offer health insurance benefits to their employees.

Influencing Decisions About Child Care

NAEYC's influence on child care policy focuses mainly on the development and promotion of position statements. Examples include

NAEYC Position Statement on Nomenclature, Salaries, Benefits, and the Status of the Early Childhood Profession (1984c), *NAEYC Position Statement on Prevention of Child Sexual Abuse in Early Childhood Programs* (1985e), and *NAEYC Position Statements on Child Care Licensing and Family Day Care Regulation* (1984b). These statements are useful resources to child advocates promulgating policy changes in states, agencies, and boards.

Public information materials provide another way to influence the child care decisions of parent-consumers and employers. Over 100,000 copies of a brochure titled *How to Choose a Good Early Childhood Program* (1983) are distributed each year. In response to the corporate world's growing interest in assisting with the child care needs of its employees, NAEYC has prepared an *Information Kit on Employer-Assisted Child Care* (1986). A pamphlet titled *The Crisis in Infant and Toddler Care* (1985b) was produced by the Ad Hoc Day Care Coalition and distributed to all members of Congress and major state officials. Demographic fact sheets such as *In Whose Hands? A Demographic Fact Sheet on Child Care Providers* (1985d) and *The Child Care Boom: Licensed Programs, 1977 to 1985* (1985a) provide additional resources to people seeking facts about the child care field. If knowledge is power, these public information materials will have a positive influence on decisions being made about child care.

DISCUSSION

Elinor Guggenheimer: Is accreditation for one year or three years?

Marilyn Smith: Three years. Each year the center has to file some updated information, but every three years it will have to go through the entire process of on-site validation.

Susan Aronson: Are you setting up any kind of system to prevent abuse or to deal with anyone who claims accreditation falsely?

Marilyn Smith: This is where our network of 50,000 members can help, especially our affiliate leaders. There are 350 local and state affiliate groups, and the leaders of those groups already report misuses of NAEYC's name. We will ask our affiliate leaders to check the Yellow Pages for advertisements using the accreditation logo, and we will check them out.

Susan Aronson: Are you planning to publish lists of accredited centers? That could be a good marketing strategy.

Marilyn Smith: Yes, exactly.

Juanita Fleming: Are the validators from the same state as the center? They are? I think that might not be a good idea, because of the politics. Having them come in from a nearby state would be better. You do have to be concerned about expenses, but you don't want to build in anything that could appear to bias the process in any way.

Marilyn Smith: We debated that issue long and hard. We had to keep our fees low, and that determined it. A significant part of our policy is that the on-site person does not make the accreditation decision. The commissioners, who make the accreditation decision, cannot be from the state where the center is located.

We also give the validators specialized training, a clearly defined system of observing, recording, sampling, and validating, interviewing the director and taking down information, to test the accuracy of the center's statements in the Program Description.

Moreover, when the validators are assigned to a program, they will be asked whether they can be objective about the assignment. Anyone who has had any connection with a center cannot serve as validator for that center. Also, the center director has the right to reject a validator if he or she can show cause why that validator could not do an objective validation. Finally, in most cases, because of the size of the center there will be two validators, and sometimes three. That will give another check on objectivity.

We know the system is not foolproof, but those are our responses to that concern. We had to keep this affordable; otherwise the centers will not get involved. The application fee to get all the self-study materials goes from \$50 to \$200 on a sliding scale according to size of the center. The accreditation fee, to pay for the validators coming on-site and for the commission, goes from \$200 to \$500. The validators and commissioners get no money, incidentally — only their expenses.

Elinor Guggenheimer: But it's good business for the center, because once they're accredited they can advertise it.

Michael Yogman: What will be the relationship between the accreditation process and state licensing agencies?

Marilyn Smith: Licensing is a fundamental baseline: you can't apply for accreditation if you aren't licensed. But as you know, licensing

standards vary so greatly that in some states they look very similar to our criteria and in others you could hardly recognize them. We had to make a decision: were we going to base our criteria on what we know is best for children, or were we going to base them on what the states can manage? Because we are voluntary and represent a profession, we felt that we could make this statement and that maybe in five or ten years we will find licensing standards coming closer to looking like ours. Two of our field test sites were in states that have very low licensing standards, and in both cases we got foundations to invest in the field test and in training validators, because they wanted to stimulate their states to get involved.

Susan Aronson: Remember that the function of licensing is different from that of accreditation. The function of licensing is to establish the floor below which no program should fall. I would hope that accreditation is never targeted to that level but establishes a standard to which all programs should aspire. Some states might say, as they do for individual directors' credentials and the like, that if a program were accredited it might meet their licensing standards.

Marilyn Smith: We already know of some states that are considering saying that the center can take the option, every third year, of going through this system rather than their own.

Margaret Wishart: We've recently gone through an accreditation process at Rikers Island and have in fact become the first prison health service in the country to be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH). Built into that process was an advisory service on the part of JCAH; in addition to sending us materials, they sent an advance guard, so to speak, that would tell us if they didn't think we were ready.

Marilyn Smith: We don't have that service, but we are encouraging our affiliates and other groups to become resources to centers and their communities, to advise them and help them make improvements. Also, some center directors are volunteering to be validators and coming to validator training in order to find out how to get their own centers ready.

Sandra Scarr: Have you had any indication of interest from the large chains of proprietary centers?

Marilyn Smith: Yes, two that I know of have followed the development of the project and are planning for their centers to be involved. In

both cases their educational coordinators are building their training programs around our criteria and will decide when each center is ready to go up for accreditation.

Rebecca Fewell: It would be helpful to centers to have a series of video tapes that show a center going through the process. Start from the beginning, with the staff sitting around discussing whether or not they are going to apply, and then follow them as they work through it together, all the way to the end, where they get their accreditation.

Marilyn Smith: We have submitted proposals to do what you are talking about. Meanwhile, we do have a fifteen-minute video of Susan Bredekamp, the director and major designer of this project, describing the process. It is available on loan to anyone who wants to have a meeting in their community or in their center. We are also developing video tapes for training purposes. We think they're a very effective training tool within the center, taking advantage of short breaks within the day.

SUMMARY

SOME REMAINING QUESTIONS

Bettye M. Caldwell, Ph.D.

As the various presentations have been given, I have been writing down certain important issues that were discussed, either in the papers or in the discussions that followed. There are seven questions that it seems to me we have been asking over and over:

1. How do we define our services?

My first question, which I think we have discussed in many ways, relates either directly or indirectly to some of the issues I brought up in my opening discussion about the concept of child care. We still need to ask ourselves how we define our services. What is it that we are offering? What sort of amplification of our services, either in our own minds or in the minds of the consumers, is necessary if people are really to understand that we are a comprehensive service and that we do indeed provide this continuum? Repeatedly, people brought up

issues that relate to how we generate support. Do we broaden or narrow our concept? Susanne, you remember, reminded us that it might be a good idea sometimes to link our request for support to requests for support for programs for the elderly, to bring in the handicapped with the nonhandicapped, and so on. If we think of child care services as representing a continuum from very little supplementary care to a great deal of it, then certainly we need to have the people who are offering part-day services realize that they too are speaking prose, that they are part of this continuum of care.

Dana, I think, mentioned that some centers that operate the full-day service will not take children for part of the day. They say, "Well, we have to pay the staff for the whole day. We cannot take a part-time child unless we can fill the rest of the day with another part-time child who matches" — an economic reality from the standpoint of the program operator, but a flaw in the pragmatic aspect of thinking of this as a continuum. So, how we define our services seems to me to be still a very important question that we have to ask.

2. Who uses our services?

The second of my seven questions relates to who uses which of our services. Ellen began her talk by saying, "Who cares for the children?" Then Marilyn described the new booklet by NAEYC, "In Whose Hands?" It is a very disturbing thing to realize that with child care a century old in this country, having been reformed for a good twenty years, we still cannot do a head count, or a center count, or a count of family day care homes, and identify where our children are in child care. It is nothing short of a disgrace that we can collect data and have to ask the question, "Does that include part-time care?" We are still at the stage of not adequately defining our services and not being able to say who uses which type of service, and as a consequence we put out all sorts of misleading statistics about the utilization of child care.

3. How do we ensure equal access?

A third question that came out repeatedly in the presentations related to the issue of equal access. Sandy, you pointed this up. You

said, "I'm worried that the split is getting wider between the affluent and the poor in the availability of services." Maybe we now have more spokespersons for the handicapped, but we still need somebody who speaks for the poor. There are many organizations and many individuals, I'm sure, who see themselves in that way, but in spite of all the speaking, it may well be that child care services are becoming more costly and less available to the poor and the working poor. Ensuring equal access to services is a big issue.

Ellie, you brought up in your paper some examples of rather unusual types of child care needs. We have tended to think of 8 a.m. to 4 p.m. as the full day. But you find that even 7 to 5 is not enough, or 6:30 to 6:30, and you give the example of the woman who works odd hours at night. Only hospitals, to the best of my knowledge, have really developed any kind of service for these odd hours. But that's all part of assuring equal access.

4. How can we avoid conflicts with those we serve?

A big issue that came up repeatedly in our discussions dealt with learning to avoid conflicts with those we serve. As you think back on the discussions, think how often the potential for tension between parents and providers has come up. This conference has brought that into sharper focus for me than before. There is something of a paradox — Mike referred to this — in the professionalization of child care. Perhaps it automatically pulls the providers and the parents apart. The providers need to exalt their own professionalization more than people in other areas do, precisely because they feel underappreciated.

The mechanics of child care provide a perfect set-up for conflict. We gave a lot of examples of it: the parent who consistently comes late, with no apparent realization that whoever is on late duty at the center also has children to take care of and dinner to prepare. Similarly, when a center puts on a heavy extra fee for parents who come late, which is a fairly common practice, the parent can see the providers as being unsympathetic.

The whole business of the professionalization of the rearing of children is interesting. It is something that we have not dealt with, and perhaps our great thinkers have not dealt with it enough philosophically. There are some very profound implications of the idea that the care of children does indeed merit some kind of professional training. One of the reasons it is difficult to gain acceptance for it is

that if we admit that what we do with our children is vitally important, then we have to deal with the possibility that we functioned poorly if things do not turn out as we expected. That is, it is fine to take the credit for facilitating optimal development of our children when they do well. But if you flip that coin over, the tail side says that you then have to assume some of the responsibility if they do not develop according to your specifications. The head side of that coin is a lot easier to accept than the tail side. In general we can find all sorts of extenuating circumstances to explain our children's problems, but at the same time we like to take credit for their achievements.

5. How do we assure quality?

We had much to say on the question of quality. Obviously this is one of the biggest issues that we have to deal with at the present time. Sue brought up several important things about the role of monitoring. I find it paradoxical that people seem to be afraid of monitoring in the child care system. Sue said that monitoring in and of itself is a form of technical assistance. That is an excellent way of conceptualizing monitoring. We are finding that in the accreditation procedure, as Marilyn said, simply getting those forms and seeing how you are going to be looked at is a great internal impetus to change. One area in which we desperately need more monitoring is family day care. The nature of that system is still such that the incentives to conceal are very great. If you don't get yourself licensed or registered, whichever your state requires, you might insist that your parents pay you in cash and not have to pay taxes on that money. Likewise the mother, the consumer, can negotiate and pay a wage that is less than any sort of minimum wage that the law might require. Somehow we need to demolish those incentives, so that we can bring this service out in the open.

In terms of assuring quality, we had much to say about securing interdisciplinary involvement, and I thought there were some excellent points made on this. Judy talked about barriers to interdisciplinary involvement. They are great. Someone mentioned the fact that the salaries are so unequal that there is still a lack of trust between and among the various disciplines. There are feelings on the part of the people who do the everyday work that, "Well, these people come in once a year, and they don't know the children, and they don't know the problems I face," and so on. All this, perhaps, is conducive to an

inability to accept the contribution that persons representing other disciplines can offer.

Ellie spoke repeatedly of turf and turf-guarding. The ownership of child care turf has probably never been fully decided; it's like a soccer game, with a lot of movement up and down the field. I hope that it isn't ever settled, because I want us to realize that this is something that everybody should possess. There is no question but that interdisciplinary involvement is difficult to achieve, particularly for the small isolated programs that probably need it the most. This is always one of the paradoxes that we have to face. Judy made the point that few physicians and nurses are adequately trained for community work of any sort. Certainly there is a need to strengthen mutual respect and a recognition on the part of all the disciplines that those on-line providers do have a great deal of knowledge and wisdom and awareness to contribute to any such arrangement.

The need for training has also been stressed, and I think that to some extent we've all been seeing in one form or another that training as it is now offered still needs to be improved. The need to build health care provisions into the training, absolutely without any allowance for excluding them, is so easy to see now.

The training provided caregivers does not as a rule give enough recognition to the emotional needs of children. If we go back twenty years or so, this was virtually all that training dealt with. Many professionals were concerned that the emotional needs of young children — especially infants — could not be met in child care settings. People who came into the field primarily because they saw it as a setting in which cognitive development could be enhanced had to try to provide assurance that such an emphasis would not compromise the children's emotional development. It is quite possible that in our training today we do not give enough attention to this subject.

A final component of the task of ensuring quality involves meeting the needs of the staff. Over the years my own concerns have broadened to include the needs of child caregivers. I used to object when anyone suggested that child care was a service for parents, as I was so exclusively focused on it as a service to children. Although I have never lost sight of my concern for the children, I certainly have come to accept the fact that child care is a vital service to parents. But in addition it has to meet some of the needs of the staff. Anyone active in this field knows that child care workers are generally overworked and underpaid and undervalued by society. Yet we are employing them to supplement the parental role in meeting the needs of the children, and

they cannot do this unless some of their own needs are met in the caring arrangement.

In this context, Sue reminded us of the importance of being concerned with the health care needs of caregivers. As you spoke, Sue, I found myself thinking of the thousands of caregivers who work on an hourly basis and less than half-time, precisely because the employers then do not have to pay health benefits. If these workers get any health care, they have to do it on their own time and pay for it themselves. When you are making only minimum wage, paying for such care is not easy. We need data on the health care needs of caregivers, and I don't know of a single study that has been concerned with this issue. Anyone who has worked in such settings will tell you that you are sick half the time your first year. During the second year you toughen up a bit, and finally you develop enough immunity to enable you to be in contact with children on a continuing basis. But we need to be concerned with the health needs of caregivers as well as their financial needs.

And finally, as Juanita reminded us, we must recognize the self-esteem needs of caregivers. Of course, these needs can be met only partially in the employment situation; society at large has a major responsibility in this respect. Caregivers' needs for self-esteem cannot be realized until the general public has more appreciation of the importance of their work.

6. How do we market our product?

There is a new awareness everywhere that we need to pay more attention to the task of marketing child care to the public. In her presentation Ellen mentioned the paradox of reading about the tremendous need for licensed child care on the one hand and on the other hand talking to providers who have empty places in their facilities. Although many centers now advertise in the Yellow Pages of the local telephone directory, there is still a reluctance on the part of most professionals to reach out to prospective clients. It is as though they fear that even the simplest announcement of their existence will somehow suggest to people that their programs are not of the highest quality — that is, that the *best* programs do not have to advertise. But planning a marketing strategy and advertising are not the same thing, and it is clear that we need to devise such a strategy and put it into action.

Someone mentioned that health care professionals are now recognizing the necessity of marketing their services. And Sue mentioned that child care providers could help in the marketing of other services to children through their contacts with children and parents. Effective contacts with the business world — such as those made by Dana, Ellen, and Ellie — have made a big difference in gaining greater public acceptance of child care. Such contacts are themselves a vital part of any marketing strategy. And yet many of us still resist thinking about any aspect of marketing and consider it beneath us. All we have to do is to make these wonderful services available and the world will beat a path to our door. But of course that hasn't happened in child care.

In addition to marketing the service, we have to market the correct concept. Many people, including state legislators, still think of and refer to child care as baby-sitting. If we don't communicate more accurate concepts, people will continue to think of the service as synonymous with baby-sitting. When they do that, they think it ridiculous to talk about requirements for training and standards for the care. So we have to market correct concepts as well as the external product, the service actually provided.

7. How do we develop a national policy for children?

My final question has come up repeatedly in the discussions. A key word in the question is *national*. The current tendency to refer all issues pertaining to children and families back to the states is inimical to the development of a coordinated national policy. Child care is in about the same position with regard to the state-federal issue that education was in some twenty-five years ago. Federal aid to education and national policies relating to educational issues (such as desegregation of schools) are of surprisingly recent vintage. Any sort of federal policy about education was seen as a violation of states' rights. There is still a strong proclivity for state or even municipal policies that in any way impinge upon family life and a deeply ingrained suspicion of federal regulations. Somehow we have to overcome this deeply ingrained resistance if we want a national policy pertaining to children.

Developing Guidelines for Action

As you know, one of the objectives of this Round Table was to develop a set of guidelines for action for use by professionals and directed toward achieving quality child care. As a framework for our discussions of these guidelines, I have developed the matrix that I am showing you here. On the vertical axis of the matrix are certain goals on which we need action. It has seemed to me that the issues we have brought up fall into four main categories. The first, dealt with by most of us in one way or another, relates to *making available a system of comprehensive services*. The second issue appeared in many forms and guises but always touched on the need to *change the image of child care*, to replace the concept of the service that most people seem to hold with more accurate concepts regarding professional realities (it is not just custodial care or baby-sitting) and social conditions (it is not for pathological families but for all families). The third major issue deals with the need for *training and technical assistance*, and the fourth with *achieving and maintaining quality*.

On the horizontal axis I have identified three arenas in which we need to take action to deal with these issues and achieve these goals. The first arena is *professional*. What can different professional groups do to help achieve whatever action is needed in these four areas? Then we need to think about what sort of *political* action is needed. Finally, in order to achieve any of the goals, some sort of *public* action or reaction will be needed. And this action will have to come from the entire citizenry, not just from clients or child care services.

Now I would like to open the floor for discussion that is guided by this matrix. As we specify what sort of action should be taken within each of these arenas with respect to each issue, I think we will be working out a strategy for coordinated action pertaining to the issue.

Editor's note: The completed matrix that resulted from the subsequent discussion is presented in the appendix.

APPENDIX

APPENDIX: GUIDELINES FOR ACTION

Goals	Professional
I. Making available a system of comprehensive services	We must define what services we want to offer, including part-time care, and develop the local expertise to deliver those services. We must develop networks of affordable consultative services, including a public health resource for every child care program, to ensure that professional help is available to all groups in the population. We need active outreach programs to provide auxiliary services to children not otherwise accessed. Technologies such as computers should be used more fully in delivery of services.
II. Changing the image of child care	We need to develop better linkages with other institutions that serve children and parents, such as education. Researchers can engage in policy-relevant research that will serve to inform others of the positive benefits of child care. We must work to improve child care workers' self-image by improving their social and financial status.
III. Developing a system for training and technical assistance	Better training for all child care personnel is a critical need. Technologies such as satellite broadcasting can be used for training. Program monitoring can serve as in-service training. Early childhood education and in-service training must include health training. Consultants working in child care settings should be trained to be learners as well as teachers. Improved resource and referral networks will stimulate and link resources at the local level. Technical assistance should include a medical professional available to every program (family day care and centers), on site and by telephone.
IV. Achieving and maintaining quality in child care	Children need care from loving and competent caregivers. The profession must continually work to bring the present continuum of quality up to a consistently high standard. Continuing research is needed into the dimensions of quality care. Research should include broader dependent variables such as parents, siblings, and worker performance. Low salaries and excessive demands on the caregiver's time and energy are current barriers to quality, barriers that the profession must seek to remove.

Arenas for Action

Political

Politicians must be made aware of the importance of child care as part of the child-rearing system at all socio-economic levels. The cost-effectiveness of public support for child care must be demonstrated, so that policy makers will see child care as a means of enabling the poor to become self-sufficient. To secure political support, child care must be presented as a family need, for men as much as for women.

Policy makers must be made to see child care as a service for all children, not as a service for the poor. Its benefits in reducing stress and thus strengthening family life should be emphasized. The value of the behavior modeling effect that working parents impart to their children should be made clear to policy makers in both the public and the private sectors.

The costs of training must be built into the costs of public child care programs.

Poor quality child care can result in injury and illness in children, guilty parents, and damaged future taxpayers. Politicians must be made aware that quality child care cannot be cheap care. There must be continuing work to upgrade licensing and registration standards for child care providers, and to provide for frequent monitoring of child care facilities.

Public

Child care must be made available to all, at affordable prices and in locations accessible to all. It must be made a system that meets the needs of both children and adults and of special groups within the population. Child care must not be allowed to become a two-tiered system, with educational programs for some and custodial care for others, but must offer rich programs of age-appropriate activities for all.

Cultural changes underway as women enter the work force will facilitate attitude changes, but appreciation of the value of child care can be fostered. A media blitz could raise the consciousness of the public. Child care groups and women's groups need to be mutually supportive, but child care should be recognized as a family service, not as a service just for women.

Parents need training in what to look for in child care and what to expect of it. There is a special need for public awareness with regard to family day care — its opportunities, challenges, and problems. Parents must be aware of potential conflicts with child care providers. Parents can learn from the caregivers, but they are also potential trainers of child care personnel.

The public must be kept informed about what constitutes quality care and how it can be obtained. But care must be exercised not to build unrealistic expectations that cannot at present be fulfilled. Parents must be made to see the relationship between quality care and cost, especially to understand that quality care cannot be maintained unless salary levels for caregivers are high enough to attract competent, dedicated workers.

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